AMA Journal of Ethics®

Moral Psychology and "Difficult" Clinician-Patient Relationships

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FROM THE EDITOR
Interrogating Assumptions about "Difficult" Patients and Situations

Labeling a patient "difficult" was described in the medical literature as early as 1967 [1] in an article entitled "The Difficult Patient." Psychiatrist M. Y. Ekdawi observed:

> It is usual to encounter, in any large mental hospital, a group of patients who are considered by the staff to be difficult. This opinion is slowly formed, but, once established and repeatedly expressed in nursing reports and medical records, it rarely alters and may have a powerful influence on the patient's career in [the] hospital [2].

Ekdawi, using a case-control methodology, characterized these patients as attention-seeking and uncooperative.

The phenomenon of health care professionals labeling patients as "difficult" is not limited to psychiatric settings and literature. In the broader medical literature, patients have been described in similar terms as "hateful" [3] or "heartsink" [4]. The description of this phenomenon in different health care settings during decades of practice and as explored in the health professions literature beckons further investigation.

This issue of the *AMA Journal of Ethics*® seeks to accomplish two things. First, it engages in reflexive interrogation of the so-called "difficult patient" as a discursive figure in medical literature and practice. Second, this issue invites health professionals and trainees to examine their individual and collective responses in situations in which it is tempting to apply the label "difficult" to a patient.

Interrogating the Label
Similar to Ekdawi, several investigators have characterized medical, social, and personal features of so-called "difficult" patients [4-6]. In recruiting participants or categorizing them as "heartsink," "frustrating," or "difficult," these studies assume that clinicians' experiences, from which these labels derive, are caused by something pathological about a patient's behavior, communications, or character. Of note, focusing on characterizing clinicians' experiences in these ways tends to represent patients negatively and in ways that can disadvantage them during their health care experiences, particularly during clinical encounters. An alternative to the assumptions made in these studies suggests that a clinician's perception of a patient—as "difficult" or otherwise—is co-produced by interactions among a patient, clinicians, and health care settings [7-11].

Three articles in this issue explore how the term "difficult" is a product of more than just a clinician's experience of a patient's behavior, communications, or character. Federica Lucivero shares findings from her qualitative research on patients' increased access to electronic health records in the UK, arguing that [infrastructure and protocols of health care systems](#) contribute to difficult patient-physician interactions. Rather than focusing narrowly on a patient's behavior, communications, or character, Elizabeth S. Goldsmith and Erin E. Krebs emphasize the importance and value of characterizing which [qualities of clinicians](#) and health care settings can make clinicians more likely to label a patient "difficult" and how training and workplace environments might be modified to nurture better relationships. Finally, Jonathan B. Imber outlines physicians' behaviors, changes in medical education, and [changes in science](#) that might contribute to difficult physician-patient relationships and encounters.

In the podcast, Autumn Fiester cogently analyzes the ["difficult patient" label](#). Fiester contends that the use of the label places too much responsibility for the conflict on the patient, often ignores context and the physician's own contributions, and leaves little hope for healing the relationship. And Merel Visse provides five visual images that represent these and other [conflicting forces](#) that can influence patient-clinician interactions.

Practical Guidance
Another part of interrogating the label "difficult" is to scrutinize health professionals' affective tendencies in these situations. Clinicians' affective responses have been considered an important element of what makes a patient "difficult." For example, in James E. Groves's landmark article about "hateful" patients, published in the *New England Journal of Medicine* in 1978, physicians' responses are characterized as "dread," "aversion," and "depression" [12]. The article about "heartsink," referenced earlier, defines these patients in terms of how they "exasperate, defeat, and overwhelm" or "distress" physicians [13]. Several articles in this issue offer practical guidance about how clinicians and trainees can become aware of and manage these kinds of affective responses to patients.

The three cases narrate situations in which patients might be characterized as "difficult." Micah Johnson analyzes an interaction between a patient dissatisfied with his pain management and an impatient resident; he argues that a physician's duty to treat a patient confers upon him or her [responsibility to repair a damaged relationship](#) with that patient. Monica Peek, Bernard Lo, and Alicia Fernandez respond to a case in which a woman refuses to be examined by a man during his obstetrics/gynecology clerkship and consider some of the ethical dimensions of patients' requests for [gender-concordant care](#). And Andrew Thurston considers a case in which a physician-parent [challenges a decision](#) by her son's physician.

Four other articles provide strategies, techniques, and insights for clinicians to use in difficult interactions with patients. Richard B. Gunderman and Peter R. Gunderman critically analyze Groves's article on the "hateful" patient [3], arguing that physicians can and ought to make conscious efforts to reshape their feelings—particularly hateful ones—towards such patients. William T. Branch, Jr., and Maura George explore how different methods of reflective learning can catalyze practitioners' moral development and professional identity formation, equipping them to navigate problematic encounters with patients. Utilizing a virtue ethics framework, Michael Hawking, Farr A. Curlin, and John D. Yoon encourage educators to foster courage and compassion among trainees to prepare them for difficult interactions with patients. Finally, Denise M. Dudzinski and Carrol Alvarez appraise communication strategies physicians could use to repair damaged relationships with patients.

Conclusion

This issue of the *AMA Journal of Ethics* seeks to help clinicians and trainees investigate and interrogate some of the assumptions about and implications—for themselves and their patients—of using the label "difficult."

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ETHICS CASE

Do Physicians Have an Ethical Duty to Repair Relationships with So-Called "Difficult" Patients?
Commentary by Micah Johnson

Editor's Note: This is the winning essay of the 2016 AMA Journal of Ethics *annual Conley Contest.*

Abstract

This essay argues that physicians hold primary ethical responsibility for repairing damaged patient-physician relationships. The first section establishes that the patient-physician relationship has an important influence on patient health and argues that physicians' *duty to treat* should be understood as including a responsibility to repair broken relationships, regardless of which party was "responsible" for the initial tension. The second section argues that the person with more *power* to repair the relationship also has more *responsibility* to do so and considers the moral psychology of pain as foundational to conceiving the patient in this case as especially vulnerable and disempowered. The essay concludes with suggestions for clinicians to act on the idea that a healthy patient-physician relationship ought to lie at the center of medicine's moral mission.

Case

John is a third-year medical student on his first day with a new service during his surgery rotation. On this particular morning, John is going on rounds with the chief resident, Dr. M, and an intern, Dr. S. As the team walks down the hall to the next room, John quickly glances over his rounding sheet for a 48-year-old man, Mr. C. Mr. C had a toe amputation three days ago and suffers from chronic pain and diabetes mellitus type I. He also has a history of using opioids, and his pain medications are being carefully controlled in the hospital.

Before they enter the room, the intern Dr. S softly says to Dr. M, "Hey, just as a heads up, I heard this one was feisty last night. Apparently, the attending physician came down hard on his request for more analgesia. The patient was not happy with the refusal and gave the nursing staff a lot of trouble." Dr. M responded, "I heard about that. But he's always been difficult; I saw him in clinic last month." The team then enters the room.

As Dr. M begins questioning Mr. C, "How are you doing this morning?" Mr. C starts to moan in pain and offers short responses. Dr. M concludes his questions, "Now we're going to take a look at the toe." Mr. C begins shouting in pain as John and Dr. S remove the bandages. "Please stop!" he moans. Dr. M tries to soothe him, "I promise we'll give you more for the pain; I'll talk to your nurse when we leave. But right now, we need to get this off and take a look at the surgical site." Mr. C retorts, "You've never taken care of my pain! I've been asking for help every day, but you don't listen!"

When John rips open the packet of gauze to apply a new dressing, Mr. C angrily states, "I don't want to be touched, poked, or prodded anymore." John and Dr. S pause, bandage in hand, waiting for instructions from Dr. M.

Dr. M responds, "We're trying to help you, but we need you to work with us." Mr. C flatly refuses and shouts, "Nobody cares about my pain—you have no idea what I've been through."

Dr. M silently stares for a few seconds at Mr. C who whimpers quietly. Dr. M turns his gaze from Mr. C to Dr. S, mutters "Let's go—don't worry about the bandage," and walks out of the room. John wonders what to do with the bandage he's holding and how to respond to Mr. C.

Commentary

A fractured patient-physician relationship can be a serious threat to a patient's health. As a defining influence on patient well-being, the patient-physician relationship must be subjected to careful ethical scrutiny, and the conflict between Dr. M and Mr. C raises one of the key questions: Who is responsible for repairing a damaged patient-physician relationship?

This essay argues that the physician holds primary responsibility. The first section argues that physicians' ethical duty to treat must be understood as including an obligation to repair damaged relationships that threaten a patient's health. The second section argues that the person with more power to repair the relationship also carries more responsibility to repair it and concludes not only that physicians in general hold more power in the patient-physician dynamic, but also that Mr. C is particularly disempowered in this case because the conflict involves a dispute over his subjective experience of pain. Finally, John's role as a medical student is analyzed. Although he is at the bottom of the medical hierarchy, he can leverage his unique role as a learner to encourage thoughtful discussions of aspects of patient care that might otherwise be left to habit and unconscious bias.

Physicians' Duty to Treat

Physicians have an ethical responsibility to treat their patients, which stems both from physicians' professional obligations as well as from patients' right to receive medical care [1-6]. In general, *duty to treat* means that when a patient is under a physician's care, the physician has an ethical obligation to offer interventions necessary for improving the patient's health.

A damaged patient-physician relationship should be understood as a potential threat to patient health that compels the physician to intervene. A systematic review and meta-analysis of 13 randomized controlled trials on the patient-physician relationship found that the quality of the therapeutic alliance had a positive effect on health outcomes [7]. Importantly, the impact of the patient-physician relationship on health outcomes was greater than that found in other studies of common interventions, including aspirin for reducing the risk of recurrent myocardial infarction over five years and the influence of smoking on male mortality over eight years [8]. If the duty to treat gives physicians the responsibility to prescribe aspirin after a heart attack, it must be understood as giving Dr. M the responsibility to repair his damaged relationship with Mr. C, since the therapeutic alliance has an even greater impact on health outcomes.

One possible objection to this view is that physicians' duty to treat applies only to traditional biomedical interventions like offering pharmaceuticals or performing surgical procedures, and thus the patient-physician relationship lies beyond its scope. But the fact that some health-promoting interventions come in the form of pills while others come in the form of personal interaction cannot be a distinction of great ethical relevance. Many varieties of patient education and counseling are essential to high-quality care; the fact that these therapies involve interacting with the patient rather than filing a prescription diminishes neither their importance to patient health nor the physician's responsibility to provide them.

A second objection to holding Dr. M responsible for repairing his relationship with Mr. C is that the duty to treat must be secondary to physicians' primary ethical obligation to "do no harm"—after all, Dr. M might believe that prescribing opioids is harmful to Mr. C, even if refusing his request for analgesia damages their relationship. But this objection fails to recognize that Dr. M's responsibility for repairing his relationship with Mr. C is independent of whether the best clinical decision turns out to be not prescribing more opioids. For instance—regardless of the prescription decision—Dr. M might have responded to Mr. C compassionately instead of walking out of the room: "I'm sorry you're feeling that we haven't paid enough attention to your pain—what makes you say that?" Or Dr. M might be open about the clinical challenge: "We understand that you're in pain. There can be risks to prescribing high doses of opioids; are you willing to work with us to find other treatments to make you comfortable?" By distinguishing the quality of the patient-physician relationship from any particular prescription decision, it becomes clear

that there is no conflict with the obligation to do no harm—repairing the relationship is still likely to benefit the patient and represents an ethical duty in its own right.

A final objection to assigning Dr. M primary ethical responsibility is that if the patient is responsible for damaging the patient-physician relationship, then the patient should be responsible for repairing it. But this reasoning contradicts how we think in general about the relationship between patients' responsibility for their illnesses and doctors' obligation to treat them. Put simply, physicians have a duty to treat even when their patients are in some sense "responsible" for the condition that ails them. Pulmonologists treat chronic obstructive pulmonary disease caused by smoking; endocrinologists treat diabetes exacerbated by poor diet; and emergency physicians repair self-inflicted wounds. One of the most beautiful and essential aspects of medicine is the opportunity for physicians to care for their patients without letting moral judgment or personal bias cloud their compassion for the suffering human being in front of them.

In summary, the duty to treat gives physicians an ethical responsibility to offer health-improving interventions to patients under their care. Since maintaining a therapeutic patient-physician relationship has an even greater health benefit than some other common medical interventions, the duty to treat must be understood as giving physicians an ethical responsibility to repair damaged relationships with their patients, irrespective of whether the best clinical decision might contribute to the damaged relationship or whether the patient caused the initial tension.

Power, Pain, and Moral Psychology
The weight of responsibility for repairing any given patient-physician relationship also depends on which person has greater power to repair the relationship. In ethics, it is sometimes held that "ought implies can": that is, if it is true that a person ought to act in a certain way, then it better be possible for the person to carry out that action [9, 10]. It follows that to the extent that Mr. C lacks the power to repair the relationship, he cannot have the ethical responsibility to do so.

Hospitalized patients like Mr. C are disempowered in numerous ways: they often have impaired mobility, are in significant pain, are stripped of their clothing, are quite ill, and generally lie at the mercy of the medical and nursing staff for their basic needs. In contrast, physicians are respected professionals who hold ultimate control over treatment options and can determine when, where, and for how long patient interactions take place. In general, the power to repair a damaged relationship will lie differentially with the physician.

Medical students like John occupy a unique place between the patient and the care team. On the one hand, being at the bottom of the medical hierarchy means that John lacks the ability (and therefore the ethical responsibility) to influence certain aspects of the

patient-physician relationship—for instance, he does not dictate treatment decisions, and he cannot directly control the manner in which his senior colleagues interact with the patient. On the other hand, John's position in the hierarchy creates an opportunity for him to mediate between the patient and the physician. A savvy medical student can use this intermediate position to bridge the wide gap in power between patient and physician, listening to and advocating for the patient without carrying the additional burden of making the final treatment decision in the case.

Beyond these general considerations of the hospital power dynamic, Mr. C faces a special kind of disempowerment in this case because his relationship with Dr. M was damaged by a conflict over the treatment of pain. Pain presents a unique challenge to physicians because it is an irreducibly subjective feature of consciousness [11-13]; there is no lab test or imaging study that definitively measures pain, and thus there is no objective measure that Dr. M can use to know how much pain Mr. C is experiencing. Crucially, characterizing pain as "subjective" does not mean that it is somehow less "real" or important than what we can measure objectively. On the contrary, pain is subjective in the sense that it relates directly to what it means to be a human being and therefore the subject of conscious experience. As with all states of consciousness, clinicians can assess pain's qualitative character only indirectly—by asking the patient about it. This absolute reliance on communication and trust makes the patient-physician relationship especially critical in the case of pain. It also means that physician judgments about pain are particularly susceptible to biases and errors of perception.

There is substantial evidence of the presence and impact of implicit bias in medicine, to which physicians like Dr. M are not immune [14]. Such biases may account for findings of racial and ethnic disparities in the assessment and management of pain [15]. For instance, studies have found racial disparities in the prescription of opioid painkillers in emergency departments [16, 17]. Other studies have documented stigma and bias against patients with a history of substance use disorders, contributing to worse treatment outcomes [18]. Taken together, this evidence—which reveals disparities in pain treatment decisions and that clinicians tend to be biased against patients with a history of substance use—suggests that implicit bias may have caused Dr. M to misjudge the seriousness of Mr. C's pain, leading Dr. M to minimize the importance of the pain while Mr. C became increasingly frustrated.

Recent work in cognitive science and philosophy of mind introduces an additional possibility: Dr. M's perceptions themselves might have been influenced by his pre-existing beliefs and biases. Philosopher Susanna Siegel offers an everyday case of "cognitively penetrated perceptual experiences" [19]: Jill believes Jack is angry with her, so when she looks at him, Jack's face actually presents itself to her as angry. Jill uses this as evidence to confirm her (false) belief that Jack is angry with her. Epistemologically,

something has gone seriously wrong here: Jill's false belief leads to a faulty perception, which itself is used as evidence to reaffirm her commitment to the false belief.

In the case at hand, it is possible that Dr. M's beliefs and biases concerning Mr. C ("he's always been difficult") led him to perceive Mr. C's behavior as disingenuous or exaggerated. If so, this perception is used as evidence to reinforce Dr. M's belief that Mr. C is "difficult" (or alternatively, "drug-seeking") and, by implication, that Mr. C's complaints of pain should be treated with suspicion.

These psychological phenomena have an ethically salient consequence: patients are especially disempowered in cases in which physician bias contributes to damaging the patient-physician relationship, and accordingly physicians take on even greater ethical responsibility to guide its restoration. To understand this powerlessness from Mr. C's perspective, suppose his reports of pain are wholly genuine—once physician bias causes his reports to be doubted, what more can he do to convince his doctors that he really is in pain? Further attempts at convincing his doctors are likely to be self-defeating: by fixating increasingly on his pain or insisting on more medication, he risks being labeled as "drug-seeking." The implication of this catch-22 is that patients are uniquely disempowered when their subjective experiences are doubted. In these cases, physicians hold a special responsibility to ensure that their own biases and errors of perception are not harming the therapeutic alliance.

Clinicians can work to counteract these biases by adopting the default stance that patients' reports of their subjective experiences are genuine, taking the burden on themselves to gather positive evidence that patients might have other motives for their behavior [20]. In particular, the mere fact that patients have a history of substance use cannot be taken as sufficient evidence that they are not experiencing genuine pain—especially a patient like Mr. C who is hospitalized for an acute condition. Physicians and medical students must also be mindful about the language they use to talk about patients. Language shapes perception [21], and labeling a patient as "difficult" or "drug-seeking" may affect how their behavior is perceived and close clinicians' minds to other explanations for the patient's behavior, which in turn may lead to suboptimal treatment decisions as well as damaged patient-physician relationships.

Medical Students as Mediators
Medical students can help combat the impact of implicit bias by leveraging their unique role as learners to ask questions that make the team think critically about their assumptions. For example, John could ask, "I know Mr. C got pretty agitated back there, but he does seem to be in pain—what can we do for him?" or "What's the best way to manage pain in a patient with a history of opioid use?" Since pernicious biases avoid scrutiny by remaining unconscious, a student's questions can be helpful simply by elevating these issues to the level of conscious reasoning. As part of the care team, John

should feel empowered to contribute in ways beneficial to Mr. C's health—whether this means ensuring the right tests are ordered or ensuring the patient-physician relationship stays healthy.

Conclusion

Physicians should view repairing damaged patient-physician relationships as an ethical obligation on par with providing any other medical intervention essential to patient care and should recognize that their greater power relative to patients comes with greater responsibility to repair those relationships. Furthermore, physicians must recognize that biases can impact their judgments and perceptions—especially for subjective qualities such as pain—and that these biases can disempower patients when their experiences are not believed, leading to worse care. Clinicians can work to counteract these biases by adopting the default stance that patients' reports of their subjective experiences are genuine and by avoiding the reflexive use of labels like "difficult" and "drug-seeking" that can disempower patients and lead to faulty perceptions. Medical students can help repair or maintain healthy patient-physician relationships by using their intermediate position of power to advocate for patients and ask questions that force the team to reconsider their assumptions. Taken together, these recommendations emphasize that a healthy patient-physician relationship ought to lie at the center of medicine's moral mission.

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ETHICS CASE

How Should Physicians Respond When Patients Distrust Them Because of Their Gender?

Commentary by Monica Peek, MD, MPH, MSc, Bernard Lo, MD, and Alicia Fernandez, MD

Abstract

There are many reasons why gender-concordant care benefits patients and is requested by them. For training hospitals, however, such requests present challenges as well as opportunities in providing patient-centered care. Responding to a case in which a female patient who is having a routine exam refuses care from a male medical student, we discuss ethical principles involved in gender-concordant care requests, when it is appropriate to question such requests, and a team-based approach to responding to them.

Case

A male medical student on his obstetrics-gynecology clerkship is assigned a 35-year-old female patient in the outpatient clinic who comes in for a routine well-woman exam, including a pelvic examination and Pap test, clinical breast examination, and discussion about contraception management. The student enters the examination room and introduces himself, but the patient straightforwardly tells him that she would prefer a woman student. The student feels conflicted and confused. He is committed to patient-centered care and wants to be respectful of the patient's wishes, but he also feels some frustration at not being able to conduct clinical activities that are a routine part of education in the rotation. He is unclear about what is appropriate to discuss with patients, or even with the attending physician, about his involvement in the care of this particular patient. When he emerges from the room and lets the attending physician know that the patient refused his exam, she simply instructs him to wait for the next patient.

Commentary

There are many reasons why gender-concordant clinical care may benefit patients' health and well-being. Shared gender-specific life experiences may engender trust and help patients to communicate symptoms and concerns to gender-concordant clinicians [1-4]. Patients with gender-concordant clinicians are more likely to undergo cancer screening and utilize other preventive care services [5-8]. By contrast, patients who

receive gender-discordant care may have worse clinical outcomes [9], particularly if they delay care or unwillingly consent to gender-discordant care and subsequently withhold information that is important to the diagnosis and treatment of their medical condition [10-12]. Gender-concordant care may also lessen the embarrassment, discomfort, or sociocultural taboo that may occur during physical examination of "private" areas, such as genitals. For example, there are religious norms that prohibit some patients (e.g., some Muslims, Orthodox Jewish persons) from being touched by gender-discordant physicians [13-15]. Among some men seeking care for issues related to sexual health, there may be a sense that being examined by women is "impolite" and that discussing issues such as sexual behaviors or erectile dysfunction is improper with female students [16-18].

This paper discusses the ethical principles related to gender-concordant clinician requests and suggests a team-based approach for addressing such requests within academic medical centers.

Ethical Principles in Gender-Concordant Care Requests
This case highlights important issues that arise when patients request gender-concordant clinician care, particularly from medical student trainees. In this complicated situation, several ethical principles need to be balanced.

Beneficence. First, the patient's well-being should be the attending physician's primary concern. Putting the interests of the patient in this case first may mean subordinating both the student's personal interest in having diverse clinical experiences and society's interests in producing well-trained young physicians. While certainly not all women prefer female gynecologists, a substantial number do [19]. The strength of the preference, however, may vary significantly from patient to patient or even for the same patient, depending on clinical circumstances.

Respect. Second, the patient should be respected as a person. Competent patients have the right to refuse unwanted care, even if recommended by the physician [20]. This includes the right to refuse care from an unwanted clinician. Respecting such refusal may be particularly important in clinical cases such as this, which routinely involve sensitive, potentially embarrassing examinations (e.g., of genitals and breasts) and conversations (e.g., about sexuality, substance abuse, or intimate partner violence). Furthermore, patients should be treated in a compassionate and respectful manner, even if the student or physician feels hurt or unfairly stereotyped by the patient's request.

Fairness. Third, students and physicians should act fairly. The student in this case *may* perceive that it is unfair that he is unable to be involved in a case that might advance his education. However, patients who request a gender-concordant physician may feel that they have been treated unfairly by the health care system and society at large. For

women, there often exists a lived experience of vulnerability that has implications for the clinical encounter. For example, the prevalence of sexual assault in adult US women is estimated to be 20 percent [21], and a slightly higher rate (29 percent) was reported in one study of adult US women in primary care [22]. Because many women have had less power to make decisions about their lives and their bodies (in comparison to men), they may feel more strongly about having gender-concordant clinical care [23] and yet simultaneously feel less able to refuse gender-discordant medical care, even by trainees. As such, women's expressed preferences for gender-concordant care may rise to even higher standards of respect for personhood than what is routinely seen in clinical practice. In addition, the power imbalance in the gender-discordant care of female patients can be exacerbated by race or ethnicity, class, and other social identities that are marginalized in the US. As a result, women with multiple marginalized social identities (e.g., African-American women, women immigrants with language barriers) may be particularly at risk for not having their preferences for gender-concordance respected within clinical encounters [24-26]. Yet, even requests that reflect a patient's sense of entitlement and privilege rather than a position of individual or social vulnerability should still be considered as potentially falling within patients' right to be treated fairly in clinical encounters.

Questioning Gender-Concordant Care Requests
While there are ethical reasons to support patient requests for gender-concordant care, there are, nonetheless, circumstances in which it is appropriate to question such requests. For example, if a male patient requests gender-concordant care because "no woman can be a competent doctor," the attending physician might ask the patient why he feels that way and then explain that women students and physicians are as qualified and competent as men. The most important reason to refuse a request for gender-concordant care is when a patient's health is potentially compromised (e.g., urgently needed medical attention is delayed) [27].

While questioning patient requests for gender-concordant care can have a negative impact on the patient-clinician relationship, it is important to note that questioning such requests can also have a positive impact. It can open an important dialogue with patients about their preferences for care that may actually enhance the patient-physician relationship, signal to patients all clinicians' commitment and competence to practice patient-centered care, and help to foster an organizational culture that validates *all* students (regardless of their gender).

Team-Based Approach to Gender-Concordant Care Requests
Medical students should not address these situations alone. There are important roles for all members of the health care team to play in navigating clinical encounters in which patients request gender-concordant medical student care. Because such requests may arise from concerns about students (rather than physicians) *as well as* concerns about

gender, addressing both issues is desirable. Based on the authors' collective experience caring for patients and examining ethical issues that arise from clinical practice, we recommend the following actions for those participating in medical training.

Clerkship directors. Clerkship directors should work in advance to alert patients to the presence of medical students—through signage, patient handouts, or other mechanisms that are integrated into routine workflow—in hopes that patients will be less likely to refuse student care, in general, once they understand the educational mission of such care. In addition, clerkship directors should identify alternative clinical experiences during the rotation for medical students who could be at risk for not meeting their clinical requirements (e.g., because of patient requests for gender-concordant care). All US medical schools require that students gain sufficient exposure and skills to key aspects of clinical examinations and medical care. Many medical schools utilize standardized patients (e.g., for pelvic and urological examinations) to provide additional opportunities that complement clinical clerkship experiences [28]. Clerkship directors should utilize and expand the options available at their medical institutions and provide visible organizational leadership that signals to students and faculty the institution's proactive commitment to the clinical training of medical students.

Attending physicians. Attending physicians should help students and patients navigate requests for gender-concordant care. Like clerkship directors, attending physicians should be obligated to make patients aware of the presence of medical students through individual patient interactions. That is, when feasible, physicians should ask patients' permission to have students involved in their care, using language that helps patients understand the parameters (e.g., "I'm working with well-trained students who are taking histories and doing chaperoned pelvic exams"), identifies the student's gender in relevant clinical specialties (e.g., "The student with me today is named James Smith, and he is in his third year of medical school"), describes some of the benefits of including students (e.g., "Students have more time to spend with you during today's visit and can answer many questions that you may have about your health condition"), and provides social norms and opportunities for patient refusal (e.g., "There is no pressure to say yes to a student, and your care here will not be affected in any way if you decline").

For patients who decline gender-discordant care, attending physicians should explore the underlying reasons with the patient using open-ended language (e.g., "Can you tell me more about that?") and address patient misconceptions about gender-discordant care (e.g., "All our students—men and women—meet high admission standards, receive thorough training in professionalism, and are carefully evaluated before they participate in patient care"). Attending physicians should use these opportunities as teachable moments for medical students by modeling sensitive conversations with patients and debriefing with students after the clinical encounter. In our case study, rather than simply informing the student to wait for the next patient, the attending physician could

have debriefed with the medical student in real time to learn more about the student's interaction with the patient, stepped in briefly to make sure the patient understood clinic protocols about student participation, and had a discussion at the end of clinic that described how the patient's concerns were addressed and underscored for the student the teaching points inherent to the case.

Medical students. Medical students should understand that while their involvement in patient care is important, it is nonetheless *optional* at the level of individual patient encounters. This is particularly true in the ambulatory care setting where the acuity and severity of medical problems is lower and the need for student assistance is less urgent. Medical students should also know that learning to address patient requests for gender-concordant care (and other identity-based care), including identifying cases in which it makes sense to disagree with the patient's request, is an important part of learning medical professionalism. That is, recognizing and understanding one's own emotional responses to patients (e.g., anger, confusion, ambivalence, sadness) while recognizing the primacy of patient care and well-being is an integral part of professionalism and a skill to be honed during medical training. Finally, medical students should seek support and guidance from their attending physician, clerkship director, and physician mentors to help navigate, and learn from, clinical encounters such as this. In our case study, the student could have asked the attending physician for specific feedback and guidance on how to address the patient's request, thus prompting discussion about gender-concordant care requests.

Conclusion

In summary, patient requests for gender-concordant student care present challenges and opportunities for medical students, physicians, and institutions to simultaneously promote patient-centered clinical care and training in medical professionalism. There are many reasons that patients may request gender-concordant care, and how institutions and clinicians address these requests requires thoughtful engagement with the ethical principles of patient well-being, respect for persons, and fairness. Medical students should acknowledge their emotional responses to the situation, promote the primacy of patient care, and seek help from their attending physicians, clerkship directors, and institutions in navigating these clinical scenarios.

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How Should Clinicians Respond to Medical Requests from Clinician Family Members of Patients?

Commentary by Andrew Thurston, MD

Abstract

In the medical profession, receiving a request for medical management from a colleague is a routine experience. However, when the colleague is a family member of a patient and the desired or requested medical intervention is not medically indicated in the attending physician's view, the situation becomes more complicated. Ethical issues include respect for patient autonomy and social justice as well as nonmaleficence. Furthermore, interpersonal and professional relationships may be tested in this situation. Addressing the colleague's concerns with empathy and respect, without compromising one's own medical judgment, is critical in resolving these kinds of conflicts.

Case

Dr. Rose, a family medicine practitioner, is seeing patients at her outpatient clinic. The nurse, Jack, hands her the chart saying, "Room two is ready. It's Dr. Little; she brought in her son, Andrew." Not having had time to look at the chart, Dr. Rose asks, "What was the chief complaint?" Jack responds, "Andrew has back pain." After taking a few minutes to glance through the rest of the chart, Dr. Rose exits her office, walks down the hall to room two, knocks, pauses, and enters.

Dr. Little—a vascular surgeon at a nearby hospital whose family is part of Dr. Rose's practice—greets Dr. Rose, "How's clinic today?" Dr. Rose replies, "Not too bad." Dr. Rose then turns to Andrew and asks, "What brought you in today?" Andrew says, "I've been having back problems for the last several weeks, particularly after wrestling practice." Dr. Rose locates Andrew's pain in the lower back and then performs a thorough neurological exam. Finding no evidence of any neurological deficiencies, Dr. Rose states, "This is likely musculoskeletal in nature, I would recommend rest and perhaps some pain killers. If it doesn't go away in 4-6 weeks, then come back."

Dr. Little responds, "Would you mind imaging it? An MRI or even a CT would do."

Dr. Rose replies, "None of the guidelines suggest imaging for this clinical presentation—study after study has shown that it's not beneficial."

Dr. Little responds, "I know imaging might not be helpful for the average patient, but it would be helpful just for our peace of mind to know that there's nothing rare going on."

Commentary

Dr. Rose finds herself in a tough situation, perhaps one that many clinicians find equally uncomfortable: a medically unwarranted request from a colleague. Certainly differences in opinion exist among professionals in any field, but, in health care, these differences seem to carry a heavier weight—particularly if the difference in opinion involves a potentially life-threatening diagnosis [1]. In the above case, the difference in opinion is further complicated by the fact that one clinician might be considered experienced in the diagnosis of lower back pain and the other clinician inexperienced.

Treating clinician colleagues or their relatives raises special concerns. Evidence suggests that caring for a colleague or a fellow clinician can generate anxiety in the treating clinician [2], and because of the duality of the patient-clinician role in these cases, care of a colleague should focus on "acknowledging the vulnerable patient in the colleague and acknowledging the identity of the colleague in the patient" [3]. Clinicians who become patients can also experience barriers to access, such as embarrassment, lack of time due to professional constraints, and minimization of symptoms due to clinical knowledge, which can affect the quality and timeliness of care [4]. In addition, children of clinicians might be at risk for lower-quality health care in part due to inappropriate delays in seeking care, treating clinicians' embarrassment about discussing personal issues with a colleague, and parents' self-referral to specialists [5]. Thus, factors other than a professional difference of opinion might be complicating this case.

Navigating Conflicts in the Treatment of Colleagues

In the above case study, there are a number of conflicts or issues that Dr. Rose must navigate in addition to balancing her role as the primary care physician of a colleague's child.

First and foremost is the clinical question of whether or not a particular test is warranted. This is a personal and professional conflict—something that all clinicians deal with on a daily basis, and something that Dr. Rose must consider based on all of her training, knowledge, experience, and every bit of presented clinical information. Should I get more imaging? Should I order that complete blood count? Should I directly admit this person to the hospital? What if I'm wrong? Certainly every clinician has, at one point, struggled with similar questions. In this situation, Dr. Rose has performed a thorough clinical evaluation and determined that imaging is not appropriate for Andrew's nonspecific low back pain, which is in keeping with the clinical guidelines for the diagnosis and treatment of low back pain [6]. Ordering a test that is not medically indicated carries with it a separate set of ethical considerations, such as whether or not

we are acting in the patient's best interest. Even a seemingly routine CT scan can lead to unnecessary radiation exposure and potential for complications like contrast-induced acute kidney injury [7, 8]. Assuming the ordered scan would be covered by insurance, Dr. Rose would have to add a diagnostic code to justify the scan—and without such justification (or by adding documentation supporting a diagnosis that Dr. Rose does not believe is appropriate), ordering a scan could be considered unethical.

Second, challenges in this patient encounter may stem from the fact that the request for more imaging is coming from a clinician who, in theory, would know whether and when such a procedure were warranted. If Dr. Little is not aware of the medical standard of practice for the evaluation and diagnosis of musculoskeletal injuries, then Dr. Rose runs the risk of adding insult to her son's injury by insinuating that she is not up to date. Or perhaps Dr. Little is well aware of the standard of practice but makes her assessment based on her experience and her individual patients' unique needs—which is certainly possible and speaks more to the "art of medicine"—while Dr. Rose strictly follows guidelines. However, Dr. Little's reason for requesting imaging ("to know that there's nothing rare going on") suggests that there may be an unidentified emotional component to her request—fear, perhaps, or anxiety that something unusual is being missed even if the clinical exam does not point in this direction. Dr. Little's emotions, which might overshadow her clinical knowledge and experience, as well as differences in the two physicians' knowledge and clinical approach, might contribute to making this patient-physician encounter "difficult."

Third, Dr. Little is part of a local practice at a nearby hospital and may interact professionally or socially with Dr. Rose on a regular basis, which might create conflicts of interest. Dr. Rose and Dr. Little may have mutual patients, or Dr. Little might refer patients to Dr. Rose or vice versa. A fear of decreased referrals may unduly influence Dr. Rose's clinical decision making in order to preserve the professional relationship and her livelihood. Dr. Little might even be considered a friend, which would further complicate the situation [9]. In fact, several medical organizations such as the American Medical Association, the American College of Physicians, and the American Academy of Pediatrics advise against [caring for friends](#) and family [10-12]. In addition, if Dr. Rose stays the course and doesn't order further imaging despite Dr. Little's insistence, this decision may affect their professional or personal relationship, which could in turn affect the downstream care that future patients do (or do not) receive. For example, Dr. Little may be reluctant to refer patients to Dr. Rose in the future if she feels her knowledge or judgment is being challenged. Perpetuating conflict with a colleague may affect business as well as working relationships with other staff members, making encounters like the above seem even more difficult to navigate.

Fourth, any intervention or procedure may have potential side effects or consequences, even procedures as seemingly benign as an MRI or CT scan. Complications could arise

from contrast dye if used, or an incidental finding may be discovered that leads to further testing that only adds burden rather than clinical benefit. Assuming that a thorough history and physical has been performed, searching for "rare things" is hardly cost effective or in keeping with medical guidelines [6].

Fifth, some might argue that Dr. Little lacks objectivity given the fact that the patient in question is her son and her emotional interests could cloud her clinical judgment. (Would she ask for the same test if the patient in question were not her son?) Although this is perhaps an expected emotional response of a parent with an injured child, it created an interpersonal conflict that Dr. Rose must try to address. For a clinician, balancing the responsibility and burden of medical knowledge with the emotional weight of personal concern can be challenging and risks blurring the lines between personal and professional boundaries [13].

Given all of the above issues, many might consider this a challenging situation, and some might label it a "difficult" patient encounter. How do you address a colleague's concerns while balancing the working relationship? How do you discuss medical guidelines with someone who should, in theory, know these guidelines without sounding condescending? Sometimes being a clinician patient can positively impact the patient experience by increased access to care and better communication about diagnostic uncertainty [5]. At other times, having a clinician family member can pose a greater challenge, especially if anxiety affects one's understanding of the medical facts or a blurring of roles leads to the patient's intrusion into medical management [2]. What, then, is Dr. Rose to do?

What Are the Next Steps?
I would argue that Dr. Little is in no way being "difficult": she is being a mother who is concerned and wants the best care possible for her child. As discussed, Dr. Little's request may be driven by emotional cues—such as anxiety over a sick child, fear of a "rare thing" or undiscovered illness, or fear of the unknown. In this situation, the key is to explore Dr. Little's and Andrew's concerns with empathy. Dr. Rose might consider speaking with them both separately, with permission, to see if any new information arises that changes her clinical judgment. Dr. Rose could assess Dr. Little's concerns by saying something to the effect of "It seems like you're really worried about something; tell me more about what concerns you." Perhaps Dr. Rose could explore what Dr. Little means by "the average patient." The fact that Dr. Rose knows Dr. Little could also add a more personal touch to the conversation. For example, Dr. Rose could say something like "We've known each other for many years … tell me, what are you worried about most?" In addition, Dr. Rose could acknowledge the awkwardness of balancing one's medical knowledge with the weight of one's emotions, the latter of which may be pulling Dr. Little further away from standard medical practice. Dr. Rose could say something like "I imagine you've seen many terrifying things in your practice, and I bet the mind often

goes there—especially when it's about a loved one. Is there something in particular you're worried about with Andrew?"

Exploring some of these emotions with empathy can often help someone see through the emotional fog of illness and grasp the bigger picture (in this case, the fact that there is no indication for further imaging). The reality of this situation is that bad news is being given: Dr. Little is hoping for further imaging; the bad news is that further imaging is not warranted and will not be ordered. As such, using empathetic communication skills in breaking this news is key. One mnemonic for responding to emotion with empathy is NURSE: "name the emotion;" "understand the emotion;" "respect or praise the patient;" "support the patient;" and "explore what underlies the emotion" [14].

Some might argue that clinicians must respect a patient's autonomy or, in this case, the autonomy of Andrew's parent, Dr. Little (assuming Andrew is a minor), and therefore order the imaging. However, respect for autonomy does not mean that unindicated tests should be ordered or that a clinician's clinical judgment should be affected by such demands [15]. Rather, it is the physician's duty to provide a recommendation based on a full assessment grounded first and foremost in the clinical evaluation. Both the patient's and family's emotional and psychosocial status should certainly be evaluated, but to order a test because someone would worry until the test is done might set up a very difficult precedent to overcome.

Conclusion

In this situation, Dr. Rose should not order further imaging because there is no clinical indication to do so. Instead, she should respond to Dr. Little's emotional cues with empathy and explore the request for imaging both with Dr. Little and Andrew. Dr. Rose should stick with the original plan of conservative management with re-evaluation after several weeks. She might negotiate a "compromise" of sorts—namely, conservative management—but if there is worsening of symptoms or no improvement after several weeks, pursue imaging. This plan would not compromise Dr. Rose's clinical determination but may alleviate Dr. Little's concerns and provide appropriate support. If there is still concern after the above approach has been taken, then Dr. Rose should offer the option of a second opinion if Dr. Little wants to pursue imaging, and she should be available to follow up with this imaging and continue to provide medical care for Andrew. Dr. Rose may also want to reach out to Dr. Little in the coming weeks to see how things are going with Andrew and keep open the lines of professional and patient-centered communication.

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THE CODE SAYS

AMA *Code of Medical Ethics*' Opinions Related to Moral Psychology and "Difficult" Clinician-Patient Relationships

Danielle Hahn Chaet, MSB

Labeling a patient in the health record as "difficult," "drug-seeking," or by another descriptor that places a subjective moral judgment on a patient can inappropriately influence how all clinicians will treat or interact with that patient. While the *Code of Medical Ethics* does not address labeling patients as "difficult" per se, it does speak to the necessity of a respectful relationship between patient and physician.

The first piece of guidance in Opinion 1.1.3, "Patient Rights," states that a patient has the right "to courtesy, respect, dignity, and timely, responsive attention to his or her needs" [1]. It is the responsibility of the physician to honor this right. In turn, patients have a responsibility to refrain from being disruptive in the clinical setting, as stated in Opinion 1.1.4, "Patient Responsibilities" [2].

Opinion 1.2.2, "Disruptive Behavior by Patients," describes the need for and how to show respect as follows:

> Disrespectful or derogatory language or conduct on the part of either physicians or patients can undermine trust and compromise the integrity of the patient-physician relationship. It can make members of targeted groups reluctant to seek care, and create an environment that strains relationships among patients, physicians, and the health care team.
>
> Trust can be established and maintained only when there is mutual respect. Therefore, in their interactions with patients, physicians should:
> (a) Recognize that derogatory or disrespectful language or conduct can cause psychological harm to those they target.
> (b) Always treat their patients with compassion and respect.
> (c) Terminate the patient-physician relationship with a patient who uses derogatory language or acts in a prejudicial manner only if the patient will not modify the conduct. In such cases, the physician should arrange to transfer the patient's care [3].

Part of the respect and trust equation means not using subjective moral judgments as patient labels, particularly negative ones, in a health record and not allowing such

descriptions that might already be in the health record to influence a clinical interaction. Doing so can undermine these essential elements of a successful patient-physician relationship.

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Reflection-Based Learning for Professional Ethical Formation

William T. Branch, Jr., MD, and Maura George, MD

Abstract

One way practitioners learn ethics is by reflecting on experience. They may reflect in the moment (reflection-in-action) or afterwards (reflection-on-action). We illustrate how a teaching clinician may transform relationships with patients and teach person-centered care through reflective learning. We discuss reflective learning pedagogies and present two case examples of our preferred method, guided group reflection using narratives. This method fosters moral development alongside professional identity formation in students and advanced learners. Our method for reflective learning addresses and enables processing of the most pressing ethical issues that learners encounter in practice.

Introduction

How does one become a more ethical practitioner? We suggest that clinicians learn ethics through reflective practice and reflective learning. Reflective learning incorporates the lessons of experience into practice and integrates these lessons into one's body of knowledge, providing context and meaning [1-6]. Reflection promotes mindfulness and self-awareness, both of which form the basis of effective patient interactions, especially with patients whom one finds difficult or challenging. Whether "reflecting-in-action" while with a patient or "reflecting-on-action" after having seen a patient [7], the reflective practitioner compares intended with actual outcomes. In ethics as well as other aspects of medicine, the practitioner considers if outcomes are optimal and, if not, what might have been done better. In this way, moral development progresses alongside professional identity formation as a lifelong process [8-10]. We will begin this paper with a case illustrating how ethics can be learned and then taught through reflection-in-action and reflection-on-action. We will then describe the various methods for reflective learning, which have been used extensively by one of the authors (WTB) to promote learning of ethics and professional development [11-14], focusing on two synopses of vignettes that illustrate narrative reflection.

Case: Learning and Teaching Ethics through Reflection-in-Action and Reflection-on-Action

One of the authors (MG), having just begun as a faculty attending physician at a busy safety-net hospital, related this story: Ms. L had been a patient on many other services many other times, admitted frequently for lupus flares and always found to have a urine drug screen positive for cocaine. I saw the patient with my team of medical students and residents, sympathizing with her about her pain and talking with her about the dangers of crack cocaine. She nodded and acknowledged that, yes, she would try to quit. She was pleasant and thoughtful and seemed to mean what she said. But when I later reflected about the encounter, it felt lackluster. Our team had done what every team before had done, and the outcome of each of those well-meaning encounters had been the same.

I returned to the bedside alone and sat beside her. I reflected to myself, "Why were we not connecting better? What was I failing to learn about her life? What could I ask that others had not?" Perhaps the most important question I asked myself was, "Why can't I understand her decision process?" And my answer was that I didn't know her decision process.

I approached Ms. L with a more person-centered approach. "What is your life like outside of the hospital, Ms. L? What makes you like to use cocaine?" Her response changed the way I practiced medicine. She looked me in the eye and opened up about her life, describing an abusive boyfriend who had socially isolated her from friends and family. She could only leave the house for doctor appointments and hospitalizations, and the only people she saw were her boyfriend's loud and crass friends who often filled the house. They brought cocaine with them, and she used it as a temporary escape. She knew all of the things that doctors had told her over the years, and she hated the drug. In her imprisonment, cocaine was the lesser of two evils.

Identifying a problem within the encounter and reflecting while I was with Ms. L—reflection-in-action—enabled me to see where we were off track and correct our course. I discussed with my team my conversation with Ms. L, and this subsequent reflection-on-action served as a teaching tool. We discussed good history-taking skills, compassion, bias and assumptions, and intimate partner violence, all of which are subjects taught in medical school and residency but not always within the context of building a caring relationship with the patient. By intertwining caring ethics into these lessons within a patient encounter, we make medical ethics more practical and approachable.

The case demonstrates ethics embedded in medical practice [11]. The physician's compassionate efforts to elicit and understand the patient's story and to empathize with—and thereby benefit—her patient illustrate caring ethics [10, 11, 15]. Reflection-in-action allowed the physician to go beyond her previous practice, which had not

included asking the patient about her life and social situation, and to establish a more deeply ingrained habit in herself of considering the patient's perspective [4-6, 16]. Later, mutual reflection-on-action ensured that her team appreciated the clinical and ethical importance of learning the patient's perspective.

Applications of Reflective Learning in Medical Education
Reflective learning, wherein a person steps back and examines the approaches to a topic or experience, has been widely adopted by medical schools [2, 13], with reflective learning exercises being integrated into existing courses or special programs [13]. The Association of American Medical Colleges recommends reflective learning among its standard learning methods [17]. Pedagogical tools include narrative reflection using critical incidents, appreciative inquiry or other learner-generated narratives, case studies, journaling, reflective dialogical exercises with peers and mentors, role plays, and practical exercises [5]. Schemes are available to judge the depth of reflection, ranging from simply telling a story to providing opinions, justifications, supporting examples, analyses, strategies, and supporting evidence [18, 19].

Reflective learning involves several related concepts. Critical reflection (based on critical theory) examines the economic and power relationships that exist within social and institutional contexts [5]. Reflexivity refers to self-reflection, in which one examines one's own assumptions and behaviors with respect to social roles and power relationships [5]. These methods can be applied to teaching ethics [18, 19].

One of the authors (WTB) has used guided group reflection on either critical incidents or appreciative inquiry narratives for medical students at Harvard Medical School, for residents in internal medicine at Emory University, and in multi-institutional faculty development programs, now applied at 28 medical schools [11-14]. Short narratives written by the learners are the subjects of discussion. The types of narratives used and the goals and methods of teaching reflective learning are described in more detail below.

Types of narratives. A critical incident (CI) in this setting is a narrative describing something that comes to mind as an important interaction, whether perceived positively or negatively by the learner [12, 13]. CI stories have the advantage of allowing students and other writers to process difficult experiences, such as challenging patient encounters, as well as to learn from positive experiences, such as having a good role model. Appreciative inquiry (AI) narratives are stories of success of a time when a learner was at his or her best [20]. The appreciative inquiry method as used in teaching medical humanism has been shown to build upon clinicians' successes by increasing their awareness of, and motivating them to meet, their patients' emotional needs [16]. Like free association, both methods uncover key experiences, including conflicts and difficulties that learners are currently struggling to surmount. AI narratives frequently address difficult situations that begin with a challenge that the learner successfully

surmounts [16]. If not discussed and understood, unresolved or partially resolved incidents described in either type of narrative may fester, producing stress and inhibiting socialization [13-15].

Goals. The author's goals for the reflective learning are threefold: first, to assist learners in becoming positively socialized into their roles and in forming professional identities; second, to enable them to process, gain perspective on, and come to terms with difficulties encountered on the road to becoming a professional; and, finally, to enable learners to become more self-aware and mindful practitioners who are capable of reflection-in-action and reflection-on-action and who are committed to their professional and ethical values.

Teaching methods. Narratives can be written prior to or in the initial 10-15 minutes of a session. Narratives should be read word for word by their writers, with ample time for listeners to process each narrative. It is important that all participants have the opportunity to read their narratives, although they are given the option to decline if they wish. Confidentiality is of course important. The group size is usually around eight. Meetings generally last 90-120 minutes with no interruptions.

The facilitator may guide the group by role-modeling behaviors that deepen the reflective learning, such as empathically posing a question to the story-writer that calls for meaningful reflection. The facilitator also may actively intervene and interpret group members' behaviors in ways that encourage them to support and empathize with other group members. A safe environment where group members feel their contributions are met with understanding allows for deep reflection as participants comfortably disclose difficult situations that they have faced in their professional lives.

Virtually all stories, like the examples now to be given, incorporate an ethical issue. Hence, these methods enable participants to develop ethically as well as professionally by processing the issues that are personally important to them. Two examples will illustrate using critical incident and appreciative inquiry narratives for reflective learning.

Teaching a Critical Incident Narrative

> An indigent woman refused to see a medical student in the walk-in clinic. The attending physician explained that it was a "teaching unit" and the patient "had no choice." The patient stormed out. The student wondered "how this patient, who fit the bill of the type of person I had always seen myself helping, actually saw me as being aligned with Dr. N against her" [21].

As facilitators, we would focus on this student's professional development and socialization into the profession while maintaining her core ethical values [8, 9]. She is

idealistic and wishes to serve the indigent. If unaddressed, this incident might foster cynicism [22, 23]. We might start by asking her how she feels about the incident. Is she angry or disappointed? The facilitator might empathize by saying, "I would have felt uncomfortable," and adding, "I might have felt helpless if I couldn't speak up." Very likely, other students would say they have felt the same in similar situations, so she would feel supported. We would praise her social conscience and her sense of justice.

The group could assist the learner's [professional socialization](#) by encouraging her to understand this incident from the perspectives of the teacher and the patient. How did the teacher justify his behavior to himself? How could the learner have taken the patient's likely perspective into account in the interaction [24]? Why is the clinic organized in this way? Can we change it for the better?

The facilitator could suggest methods to the learner for dealing more directly with the situation, such as asking a seemingly innocent question of the teacher, like "Why would it be wrong for you to see the patient?" However, we know from our experience that many students will be too insecure to confront their teacher. Reasonable goals are to assuage guilt in this medical student and to have her leave the session feeling comfortable with her role and choice of career direction and more confident of her understanding of others' viewpoints as well as feeling supported by her peers and facilitator, encouraged in her desire to help the less fortunate, and perhaps empowered to ask more questions should she encounter this type of situation in the future.

Teaching an Appreciative Inquiry Narrative

> A 22 year old female presented with complaints of fevers, night sweats and a left groin mass consistent with an acute infection. The patient spoke tearfully, "I don't want to die." The parents stood by, obviously emotionally affected. I (the doctor) [knowing that the prognosis was good] knelt down beside her, held her hand, and told her, "You are not going to die" [25].

> The next morning I ran into her [the patient's] mother. A medical student was with me. The mother stated, "I really liked how you talked to my daughter yesterday and thank you so much for taking the time to explain…" I said to the student, "This is why I love what I do. This is why I went into medicine" [26].

This faculty physician's story illustrates the potential benefits and rewards of being compassionate. The story shows how much patients and families appreciate compassionate doctoring. The teacher also encouraged a medical student to empathize by pointing out how rewarding to physicians and beneficial to patients these types of

experiences are. She then reinforced the lesson by briefly reflecting on its ample meaning.

As facilitators, we might ask the writer to reflect in more depth on the personal meaning of the story. We suspect that this physician reached a new level of ability in delivering compassionate care [16]. We would want to reinforce her new abilities as a healer and note that her action was considered by some to be courageous, in hopes of reinforcing her high level of performance and strengthening her moral commitment to humanistic values.

Conclusion

Our view of teaching ethics by reflective learning leans heavily on the process of professional identity formation. This view reflects our observations that progression of medical professionals' identity formation to higher levels may be facilitated by fully processing impactful experiences through reflection under good supervision during their development [27]. Identity formation is entwined with moral virtues and values. Kegan describes the highest stage of identity formation as becoming a person who can choose good moral values for herself and, like the physician in our AI example, internalize and live by them [8]. One can certainly profit from other methods of teaching ethics by reflective learning. For example, educators can assign students to write narratives or recall stories specifically about ethical dilemmas or difficult patient encounters. We have presented our open-ended approach to learning ethics using narrative reflection. We believe this is an effective learner-centered approach that promotes formation of professional identity as a humanistic clinician. For the practitioner, reflection-in-action and reflection-on-action enhance patient care, especially in difficult or challenging patient interactions, and promote lifelong learning of knowledge and skills.

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MEDICAL EDUCATION

Courage and Compassion: Virtues in Caring for So-Called "Difficult" Patients

Michael Hawking, MD, MSc, Farr A. Curlin, MD, and John D. Yoon, MD

Abstract

What, if anything, can medical ethics offer to assist in the care of the "difficult" patient? We begin with a discussion of virtue theory and its application to medical ethics. We conceptualize the "difficult" patient as an example of a "moral stress test" that especially challenges the physician's character, requiring the good physician to display the virtues of courage and compassion. We then consider two clinical vignettes to flesh out how these virtues might come into play in the care of "difficult" patients, and we conclude with a brief proposal for how medical educators might cultivate these essential character traits in physicians-in-training.

Virtue is what makes its possessor good, and his work good likewise.
Aristotle [1]

Introduction

In his 1978 article, "Taking Care of the Hateful Patient" [2], James E. Groves wrote about "those [patients] whom most physicians dread" [3]—patients who, as others have noted, seem to display "behavioral or emotional aspects" such as "psychiatric disorders, personality disorders, and subclinical behavior traits" that, while not necessarily related to their primary medical condition, nonetheless complicate their care [4]. What, if anything, can medical ethics offer to assist in the care of such patients? Modern health care ethics frameworks—typically utilizing deontological or consequentialist reasoning—respectively focus on rules and principles or pursue a decision that's likely to bring about the greatest good for the greatest number. In contrast, virtue ethics calls our attention to a physician's character.

Virtue Ethics and Medicine

Edmund Pellegrino [5] writes that virtue ethics is "the oldest philosophical foundation for moral conduct" [6]. It traces its roots back to Plato and Aristotle, was reinvigorated and bolstered by the likes of Averroes and Thomas Aquinas in the Middle Ages, and fell out of favor around the time of the Enlightenment [5]. In the 1980s, G. E. M. Anscombe's essay, "Modern Moral Philosophy," and Alasdair MacIntyre's *After Virtue* brought the tradition

back into conversation with modernity, and Pellegrino and others have brought the tradition's insights to bear on clinical practice [5, 7-11].

Rather than focusing on rights, duties, or utility maximization, virtue ethics focuses on the cultivation of certain traits—virtues—that, taken together, dispose an individual to act justly in a particular situation [10]. James Rachels, drawing on Aristotle, defines a virtue as a "trait of character, manifested in habitual action, that is good for a person to have" [12]. These traits, which are developed through practice, are necessary for an individual to flourish. "Flourishing" has come to be the preferred translation of Aristotle's concept of *eudaimonia*, which means something like "living well" or "faring well" [13]. It conveys an active state of genuine well-being and fulfillment.

To give a concrete example of a virtue that will be familiar to anyone in medicine, consider the virtue of temperance. A temperate person exhibits appropriate self-control or restraint. Aristotle describes temperance as a mean between two extremes [13]—in the case of eating, an extreme lack of temperance can lead to morbid obesity and its excess to anorexia. Intemperance is a hallmark of many of our patients, particularly among those with type 2 diabetes, alcoholism, or cigarette addiction. Clinicians know all too well the importance of temperance because they see the results for human beings who lack it—whether it be amputations and dialysis for the diabetic patient; cirrhosis, varices, and coagulopathy for the alcoholic patient; or chronic obstructive pulmonary disease and lung cancer for the lifelong smoker. In all of these cases, intemperance inhibits a person's ability to flourish. These character traits do, of course, interact with social, cultural, and genetic factors in impacting an individual's health, but a more thorough exploration of these factors is outside the scope of this paper.

How does one come to be virtuous? Consider the case of a prediabetic patient who, through conversations with his doctor and reading on his own, realizes that he is teetering on the edge of a serious medical condition and resolves to change his lifestyle. He might begin by foregoing his usual morning donut. He will probably struggle at first, but after choosing a healthier option several days in a row, choosing will become easier. Next, he may give up his afternoon soda and late-night snacks. As he chooses day-in and day-out to resist his appetites for tasty, high-carb foods, he will grow in temperance to the point that refusing unhealthy foods becomes a habit. Thus, by practicing temperance with respect to tasty but unhealthy foods, the patient will have redirected his trajectory away from diabetes and towards better long-term health.

Virtues are thus habits of character cultivated through practice that result in the actions essential for an individual to flourish. What then, does this mean for practitioners of medicine? Pellegrino wrote that the medical virtues "focus primarily on those traits necessary to do the work of medicine well. The good that medicine seeks ... is ultimately the preservation, promotion and restoration of health" [14]. Pellegrino lists what he

takes to be six essential virtues for the clinician: *fidelity, honesty, compassion, effacement of self-interest, courage, and justice* [5]. Defining, defending, or expanding this list is beyond the scope of this essay, but to illustrate the importance of medical virtues, we focus on two of these six—namely courage, or the strength of character that enables one to do what is appropriate or necessary in the face of fear or aversion [1], and compassion, or what Beauchamp and Childress describe as "an active regard for another's welfare with an imaginative awareness and emotional response of deep sympathy, tenderness and discomfort at another's misfortune or suffering" [15]. As we will see, courage and [compassion](#) are especially essential in the care of the "difficult" patient.

The "Difficult" Patient

As noted above, some have drawn attention to those patients who make "repeated visits without apparent medical benefit, patients who do not seem to want to get well, patients who engage in power struggles, and patients who focus on issues seemingly unrelated to medical care" [4]. Groves [2] attempts to categorize "difficult" patients into four types: *clingers* (needy patients who evoke aversion and need clear boundaries), *demanders* (entitled patients who use intimidation, devaluation, and guilt to get what they want), *help-rejecters* (pessimistic, needy, nothing-works patients who evoke self-doubt), and *self-destructive deniers* (who display self-destructive behavior, ignore recommendations, and evoke strong negative feelings). Any student or clinician who has been in practice can recognize, and likely conjure particular memories of, patients who fit these categories. Caring for "difficult" patients is an inescapable part of medicine, and thus learning to care well for these patients is an essential part of physician formation. The examples of *demanders* and *self-destructive deniers* particularly help to illustrate the importance of courage and compassion in clinical practice.

Demanders. Imagine walking into an office visit with a patient who suffers from chronic low back pain and [narcotic dependence](#). This patient is well-known to you; on your last visit you had discussed weaning the narcotics prescribed by his previous physician. "Doc, I need a refill! I ran out and the pain is unbearable!" the patient exclaims without any evidence of distress. You check the state's database and see that he filled his month's prescription ten days ago. You reiterate the need to transition off narcotics and the patient reacts with outrage: "Don't you care about my pain? It's terrible! You're an awful doctor."

To remain firm in one's refusal of narcotics for this patient requires a certain degree of courage. It would certainly be *easier* to refill the prescription and send him on his way. That would avoid the discomfort the physician would likely experience after refusing the patient's request, as patients with substance use disorders can escalate these situations through coercive language or threatening to file complaints. Nevertheless, the good physician will stay the course and refuse demands for treatments that the clinician

believes are not indicated, even when doing so means withstanding hostility from the patient. At the same time, a good clinician will resist the temptation to resent such patients and write them off as manipulative drug seekers. Here, the virtue of compassion enables a clinician to suffer with a patient, imaginatively calling to mind and lamenting that patient's experience of pain and addiction. Compassion promotes empathy rather than resentment and thus facilitates a healthier patient-clinician relationship.

Self-destructive deniers. Now imagine a patient whom you are seeing in the ICU. She is immunosuppressed and very sick with what will likely be a terminal pneumonia; furthermore, she is intermittently refusing to take the antibiotics you have prescribed for her while also refusing to consider home hospice. You discover that her pneumonia developed at least in part because she was not taking her prophylactic medications at home. Repeated goals-of-care conversations have only resulted in the patient and her family growing increasingly hostile to the care team. When a nurse pages you yet again to tell you that the patient is refusing today's dose, you might feel exasperation. You might dread another conversation with the patient, and it would be easy to simply ask the nurse to skip the dose.

The patient's health, however, hangs in the balance. Here, courage can equip a clinician to try yet again to form an alliance with a patient and persuade her to cooperate in her care—despite fearing that these efforts will fail while only consuming limited time and energy. Furthermore, compassion can enable a clinician to imagine and regret the helplessness and anxiety the patient might experience and to remain in solidarity with her simply because she is sick—notwithstanding how challenging it is to care for her. Compassion can evoke efforts to understand the roots of a patient's noncompliance and resistance, and courage can sustain a clinician in those efforts when doing so is difficult. Together, these virtues help to overcome conflict in the patient-clinician relationship that otherwise frustrates the possibility of healing.

Courage and Compassion as Virtues Necessary for Medical Practice
Martha Nussbaum and Amartya Sen discuss virtues as traits needed to overcome the challenges of life [16]. So understood, the medical virtues are traits needed to overcome challenges in clinical practice. So-called "difficult" patients test clinicians' characters, requiring and calling forth virtues such as courage and compassion. Susan D. McCammon and Howard Brody note that "the ultimate development of virtuous character" is exemplified when "such actions are habitual and are defaulted to even in times of significant stress" [17]. Without such virtues, a clinician might respond to a so-called "difficult" patient with aversion, pacification, and resentment, and could thereby fail to act in ways that facilitate that patient's healing. As Thomas Percival initially noted and Jack L. Coulehan has reiterated, physicians in their care of patients must unite "tenderness with steadiness" [18, 19].

A number of authors have argued that medical schools should make concerted efforts to instill virtues in their students [5, 7-9, 11, 17, 19, 20-21]. Such efforts will in no small part involve positive role modeling by virtuous faculty, and, as Kyle E. Karches and Daniel P. Sulmasy note, such modeling will necessarily resemble "the way in which a master musician teaches a student"—a kind of longitudinal "apprenticeship" with an exemplar "capable of recognizing and cultivating excellent performance" [22]. Educators can model what virtuous behavior looks like for their students and trainees. Virtuous exemplars can thereby help counteract the "hidden curriculum" of medical training, through which corrosive values and behaviors are so often displayed by resident and attending clinicians and thereby habituated in medical students [8, 23]. Some have argued for an educational model of formation in which lives of service are created and sustained in intentional learning communities that link the "lived experiences of mentors and learners with an interdisciplinary set of didactic materials" [20]. Schools that have adopted a similar model of moral formation tend to emphasize the use of narrative, the creation of a rich community of learners, and intentional reflective processes in a longitudinal curriculum that fosters an apprenticeship model of clinical education [20, 21, 24].

At all stages of medical education, clinicians can be trained to practice with courage and compassion. Repeated practice allows these traits to settle in more deeply as habits of character that equip clinicians to act in ways that facilitate their patients' healing—even when patients' behavior makes the clinicians' task more difficult. So-called "difficult" patients can push physicians to their limits, but, as was illustrated in the cases above, deeply ingrained courage and compassion enable a clinician to push through the difficulties to pursue patients' health even in the most challenging of circumstances.

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Repairing "Difficult" Patient-Clinician Relationships

Denise M. Dudzinski, PhD, MTS, and Carrol Alvarez, MS, RN

Abstract

Using a case example, we offer guidance for improving "difficult" clinician-patient relationships. These relationships may be repaired by acknowledging a clinician's part in conflict, empathizing with patients, identifying a patient's skill deficits, and employing communication and engagement techniques used by mental health professionals. Clinicians will inevitably take on more of the work of repairing damaged relationships, but doing so improves the odds of these patients receiving the help they need.

Introduction

Jane, a patient with hypertension, diabetes, and chronic back pain, calls your internal medicine clinic asking to see you urgently. She has missed every scheduled appointment in the past two months but calls the office several times a week requesting narcotics prescriptions or same-day appointments. You have been treating her for a year, and she rarely follows your treatment regimen. When you see her the next day, she again requests a prescription for narcotics for her back pain. As always, you suggest other remedies including exercise, nonsteroidal anti-inflammatory drugs (NSAIDs), and relaxation techniques. Jane becomes angry, confrontational, and tearful. She yells, "Why don't you believe me? You don't feel what I feel! I'm telling you what I need. I know what works and I'm in pain—lots of pain! I've tried all those routines before and they're worthless. Do you care about me at all?" Dr. Balewa tries to keep calm, but his anger escalates with hers. He tells her if she misses another appointment, he will have to stop seeing her. She storms off but calls the next day for an appointment, telling the receptionist what a great doctor he is. He is exhausted from yesterday's appointment, dreads seeing her again, and feels guilty that he can't seem to help her and probably made things worse. He feels like a failure.

Many physicians find themselves in Dr. Balewa's place. Jane regularly and urgently requests help managing her chronic medical conditions then ignores or rejects most of the care offered. She requests medications not indicated, then becomes agitated and disruptive when a prescription is not forthcoming. "Difficult" patients commonly struggle with chronic, incurable, or elusive illnesses [1, 2], which may be borne of tragedy, loneliness, poverty, or other psychosocial factors. Communication is frustrating for both

patient and physician. Despite his efforts to maintain professional equanimity, Dr. Balewa became angry and responded with an ultimatum. Both physician and patient seemed to expect failure from themselves and each other, and their expectations were met. What can Dr. Balewa do to repair this relationship?

Clinicians will inevitably encounter patients with whom they share strained and complicated relationships. Initially it might seem that the problem is due to the patient's noncompliance, substance abuse, mental illness, or demanding or disruptive behavior. In contrast, bioethicist Autumn Fiester describes the "difficult" patient as "someone who perceives himself as wronged in the medical encounter—perceives being treated unfairly, disrespectfully, dismissively, condescendingly, or offensively" [3]. By acknowledging that the difficulty resides in the *relationship*, not the patient, clinicians honor their fiduciary responsibility to take the lead in ameliorating conflict. We argue that when a clinician brings hope, encouragement, and optimism to an encounter, he sets himself and the patient up for success. In this article, we discuss communication and interpersonal strategies designed to repair difficult patient-clinician relationships.

Take Stock
After exiting the exam room, it is tempting to leave the unpleasant experience behind, but reflecting on the encounter is more productive. Ask yourself what went wrong. Ascertain how you have participated in the malignant relationship by identifying your "triggers" [4]. Do other patients, friends, or family members prompt similar reactions in you? What responses *to you* do these friends and the patients have in common? Try to identify patterns. Do you tend to feel exasperated with patients who need your help with nonmedical issues or who demand treatments you deem inappropriate?

Set Tone and Expectations
Jane's emotions got the better of her, prompting Dr. Balewa's *in*validation of her internal experiences when what she, and others like her, seeks is validation [5]. Dr. Balewa could help by lowering his voice, being still and calm in the midst of Jane's anger, and by setting concrete expectations and boundaries early in the appointment. With preparation and practice, he can de-escalate emotional intensity by creating a more collaborative atmosphere. For example, he could begin by saying, "I would like us to find a plan that we both believe will work for you, one that is within standards of good clinical care. We might have to start with small steps. In order to accomplish our goal, we will have to be respectful of each other. If one of us becomes too frustrated to continue, we may have to stop at that point and pick up again at our next visit." This approach improves collaboration and emphasizes mutual respect and responsibility, because the plan applies to both patient and physician. It also avoids the abrupt imposition of an ultimatum borne of the physician's frustration. This strategy is useful in that it allows a time-out period for the patient, and perhaps the physician, early rather than late in the escalation process. Patients with emotional dysregulation may have difficulty regaining

control once escalation has begun, and providing a structured way to interrupt the process is beneficial.

Empathize with Patients in Their Attempts to Solve Problems

It's helpful to recognize that the patients' behaviors are attempts to problem-solve. For example, Jane might believe the physician does not appreciate the intensity of her pain and distress. She believes shouting will call attention to her needs, and she is right. Often patients seek human interaction and [empathy](#) from caregivers. Jodi Halpern describes empathy as including "not only spontaneous emotional attunement . . . but also a conscious process of cultivating curiosity about another's distinct perspective" [6]. Sympathy, on the other hand, is "resonating emotionally with the patient" [6]. When the patient is angry, empathy de-escalates conflict and sympathy escalates it. After listening with interest and curiosity to Jane's angry accusations, Dr. Balewa could have said, "I know you've been frustrated and felt unheard. I'm not intending to be disrespectful of your experience. I have guidelines I must follow, but perhaps we can begin with a specific goal and try different approaches." This approach validates the patient's distress and promises a commitment to creatively resolve *the patient's* perception of the problem.

Assess Patient's Skill Deficits

Behaviors that provoke emotional reaction in others may represent skill deficits in the patient. The skills Jane lacks include the ability to effectively regulate intense negative emotions and to communicate effectively in the midst of conflict. Jane might not be able to self-soothe, expecting relief to come from external sources such as the physician or narcotics. Finally, she likely has limited experience of self-efficacy, which plays out in her inability to effectively make and keep medical appointments. If Dr. Balewa sees Jane's behaviors as coping strategies rather than noncompliance, his empathy may increase and he may be better able to help her.

Strategically Manage This and Future Appointments

Dr. Balewa suspects that Jane's diabetes and hypertension are poorly controlled due to a sedentary lifestyle and medication nonadherence. He could begin the next appointment by inquiring about one or two things that have gone well since her last appointment. This strategy would begin the session with an opportunity to reinforce (even limited) successes and could help physicians calibrate how ambitious their next steps should be. In this way, Dr. Balewa would decrease his risk of getting caught up in Jane's emotional intensity. Instead, he could: (1) help Jane maintain her composure with a matter-of-fact manner of interacting; (2) validate her reaction as understandable within her unique experience and context, rather than invalidate it within his own; and (3) refocus on tasks and strategies that are most useful to her.

Setting clear limits provides structure [7] that will help Jane over time. For example, Dr. Balewa can talk with Jane about ways to improve her ability to keep her appointments,

while also developing strategies for missed appointments and requests for next-day appointments. Dr. Balewa can invite Jane to determine whether shorter appointments at shorter intervals would work better, noting that the appointment may end early if an emotional stalemate occurs, with unfinished business deferred to a later appointment.

Once these basic and immediate structures have been established, the physician could invite Jane to set goals by asking what she would like to accomplish for herself in the appointment and in the next few months. He could ask if she would be willing to take small steps toward at least one of those goals and report back about what does and does not work. Modest recommendations generated together allow additional successes for Jane to build upon. In the face of Jane's health problems these small steps might seem inadequate to the physician, but they may allow for better health outcomes in the long run.

Finally, the recommendation that doctors spend more time listening and interrupt less is especially important in difficult encounters [8]. Physicians are inclined to interrupt the patient about 18 seconds after greeting him or her. However, it only takes about 2.5 minutes for patients to tell their stories uninterrupted, which makes patients feel heard, provides rich history relevant to the rest of the visit, and likely saves time overall [9].

Conclusion

Clinicians readily accommodate patients' physical disabilities, but they might neglect to take into account patients' deficits in social and life skills or thorny personal styles. The latter signal the need for different kinds of accommodations. Patients' personal histories may influence their expression of distress, communicated in ways that complicate their ability to receive necessary care. When a clinician encounters a patient whose behaviors are disruptive and distressing, a step back for reflection can provide a shift in perspective.

The basis of trust in the patient-clinician relationship is a fiduciary obligation to protect, respect, and heal vulnerable patients. The patient-clinician relationship is inherently unequal, and the physician marshals her knowledge and power solely to aid the patient. Consequently, clinicians always have more responsibility to repair and rebuild the relationship than patients. The strategies discussed here can help clinicians do just that.

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IN THE LITERATURE

Forty Years since "Taking Care of the Hateful Patient"

Richard B. Gunderman, MD, PhD, and Peter R. Gunderman, MTS

Abstract

Using the word "hateful" is not the only option in describing patients who induce in clinicians feelings of dread. We suggest an alternative approach to the language of hate, one that seeks dignity and perhaps even a divine spark in every patient.

Introduction

In his 1978 article, "Taking Care of the Hateful Patient" [1], James E. Groves argues that patients who fill clinicians with dread can be assigned to categories that include "clingers," "demanders," "help-rejecters," and "self-destructive deniers," and that these same categories can provide guidance to clinicians interested in managing their care more effectively. Groves's article inspired further research on not only the characteristics of so-called "difficult" patients but also factors that can contribute to patients being perceived as difficult and strategies clinicians can use to respond appropriately to these patients' needs [2].

Groves tells the story of a "self-destructive denier," a 45-year-old alcoholic whose frequent visits to the hospital over a six-year period had earned him the sobriquet "Old George." In fact, the man had become the butt of a standing joke—namely, that "the more thoroughly he was worked up, the more furiously he drank" [3]. Over the final week of Old George's life, "he was released from his hospitalization for the subdural hematoma on Monday, stitched up for multiple lacerations on Tuesday, allowed to 'sleep it off' in the back hall on Wednesday, casted for a fractured arm on Thursday, and admitted with wildly bleeding esophageal varices on Friday" [3]. Despite the best efforts of the staff, which included "pumping in whole blood as fast as it would go ... at 4 a.m. the intern pronounced Old George dead" [4]. Most telling are the reactions of the residents caring for him. The junior resident murmured, "thank God," to which the senior resident added a quite audible, "amen" [4].

Relief at being rid of a patient is a theme that echoes throughout the article, which refers to patients' cries as "incarcerating" [5], compares other patients to an "unlovable child" [6], and accuses still other patients of utilizing tactics such as "intimidation, devaluation and guilt-induction" [6] in efforts to manipulate physicians. Groves writes approvingly of a "benchmark" paper [5] by a pediatric psychoanalyst [7] who openly acknowledges

hatred toward some patients, a feeling he associates with "murderous wishes" [5]. On Groves's telling, the same author goes on to liken such hatred to the dislike "normal" mothers feel for their demanding infants, as captured in nursery rhymes such as "Rock-a-bye Baby" ("Down will come baby, cradle and all") [5]. We admit that the use of "hateful" to describe a patient may not seem objectionable from some psychoanalytic points of view, in part because psychoanalysts typically regard the unconscious as the ultimate engine of human thoughts, feelings, and attitudes. On this account, a countertransference of negative feelings from the physician's unconscious is all but inevitable, at least with some patients, and such feelings are likely to intrude on the patient-clinician relationship.

No one with clinical experience would dispute that some patients act in ungracious, self-centered, and even hostile ways. In fact, in some of these cases the difficult patients are physicians, and we know colleagues who, in the sober light of day, have looked back with embarrassment and regret at their conduct while under the care of colleagues.

The palette of patient personalities is probably as polychromatic as that of humanity itself, which raises some suspicion about the adequacy of Groves's categorization of "hateful" patients. There is a big difference between acknowledging the existence of tensions and conflicts in the patient-clinician relationship and going on to brand any individual patient as "hateful" and developing a taxonomy by which to categorize such "hatefulness."

Hatefulness and Difficulty
To say that we hate something is to express extreme ill will or aversion toward it. A hateful thing can also be described as horrid, insufferable, odious, loathsome, abhorrent, repellent, and vile. If we respect both the integrity of words and the professional calling to care, then we should be quite wary about ascribing hatefulness to any patient. Psychoanalysis is both limited and problematic as a means of gaining deeper insight into our distressing reactions to patients. For one thing, psychoanalysis tends to focus its attention on primal impulses at work in the unconscious of the patient or physician, but other forces from different sources may play an equal or even more important role. We believe that Groves's perspective on what has come to be called the "difficult patient" is too limited, and that there are other more fruitful ways to understand the patients he labels "hateful."

Consider, for example, the radically different perspective of a twentieth-century figure whose renown and influence rivals that of Sigmund Freud, the father of psychoanalysis. We have in mind Saint Teresa of Calcutta, more commonly referred to as "Mother Teresa," founder of the Missionaries of Charity. St. Teresa established her order in 1950, at a time when India's poverty rate was estimated to be 65 percent [8]. Many of the homeless, impoverished, sick, and dying human beings she cared for might be described

by some as "difficult." Once she was asked how she could bear to lift up, bathe, dress the wounds of, and even embrace such apparently repugnant human beings. Her answer, quite simply, was this: "We try to pray through our work by doing it with Jesus, for Jesus, to Jesus. That helps us to put our whole heart and soul into doing it. The dying, the cripple [*sic*], the mental[ly ill], the unwanted, the unloved—they are Jesus in disguise" [9]. In contrast to "Taking Care of the Hateful Patient," St. Teresa invites clinicians and other caregivers to serve a higher purpose, one that calls forth an ethic of love, as opposed to the vocabulary of hate. The fact that love is not always the easiest or most natural response to some patients in no way diminishes its urgency.

How Groves Might See the Ethic of Love
Clinicians who are prepared to call patients "hateful" will likely find little convincing or ennobling in such an account. Consider the response of the members of Old George's health care team. They treated him as an object of ridicule, and the news that he has finally died met not with sadness but irony-laden, pseudo-religious expressions of gratitude: "thank God" and "amen." While they deliver medical care to Old George, they don't seem to care for him in any deeper sense, betraying very little appreciation for their patient's dignity. The care they provide is exclusively focused on the episodic management of acute medical problems. No one evinces an awareness of the life Old George leads outside the hospital or the possibility that a better understanding of the man might open up opportunities to make a bigger difference in his life and health.

We can only speculate on how St. Teresa might regard Old George. Would she see a lonely human being who believes that no one cares for him or sees any worth in his existence? Would she detect the complete loss of hope, a man who sees nothing in life worth living for? Or might she discern an overwhelming sense of self-loathing? It is difficult to know for sure. But there are a couple of things we are confident about: St. Teresa would likely resist the temptation to allow her attention to settle on Old George's off-putting features. Beholding even this seemingly forsaken human being, she would likely search for a glimmer of the divine.

Some health professionals might dread an encounter with Old George, seeing his existence as a burden, perhaps even a curse, and wishing for his death to bring an end to their distress. But St. Teresa, catching in the sight of Old George a flicker of divinity, might well regard him as both a blessing and a cause for thanks. While St. Teresa's perspective might come naturally to a clinician operating within a Christian tradition, we believe that even nonreligious health professionals can develop their ability to see the humanity in each and every patient. Those who cannot see Christ in their patients can still strive to glimpse their own reflection or that of someone they care for.

Consider the great physician-humanist William Osler, who wrote movingly of what it means to care for patients without invoking any divine warrant [10]. For example, Osler advises:

> Care more particularly for the individual patient than for the special features of the disease.... Dealing as we do with poor suffering humanity, we see the man unmasked, exposed to all the frailties and weaknesses, and you have to keep your heart soft and tender lest you have too great a contempt for your fellow creatures. The best way is to keep a looking-glass in your own heart, and the more carefully you scan your own frailties the more tender you are for those of your fellow creatures [11].

Groves criticizes Osler because his voluminous writings fail to address the negative feelings difficult patients can stir up, concluding that he offers only "sermons, more inspirational than practical" [5]. Why didn't Osler address the problem of "hateful" patients head on? Groves seems to imply that the very existence of such feelings was simply too painful for an idealist like Osler to contemplate. But other explanations are possible. Perhaps Osler fails to discuss the "hateful" patient precisely because, in his view, referring to any patient as "hateful" would betray a rich and venerable legacy of compassion, fomenting in clinicians the deadly presumption that we are somehow cut from a finer cloth than our patients.

Conclusion

From a psychoanalytic perspective, antipathy toward "hateful" patients may appear to be one of the most powerful forces in the physician's psyche. But from another point of view—the one embodied by St. Teresa and Osler—such sentiments may be likened to emotional clay that needs to be reworked and reshaped according to a higher purpose. Simply put, treating any patient as "hateful" warns us that we are perceiving neither the patient nor our calling in the proper light. When this happens, an appropriate response is not to resort to the sort of psychological judo practiced by those caring for Old George and especially not to give into the temptation they did by making patients the butts of our jokes. Far from it, an appropriate response is to redouble our efforts to glimpse the dignity—perhaps even the divine spark—in every patient.

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Lessons about So-Called "Difficult" Patients from the UK Controversy over Patient Access to Electronic Health Records

Federica Lucivero, PhD

Abstract

Increasing numbers of patients have direct access to their electronic health records (EHRs). Proponents of direct access argue that it empowers patients by making them more informed and offering them more control over their health and care. According to some proponents of patients' access to EHRs, clinicians' concerns about potential negative implications are grounded in a form of paternalism that protects clinicians' authority. This paper draws upon narratives from patients in the United Kingdom (UK) who have access to their EHRs and suggests strategies for moving beyond these controversies between proponents and critics of the system. It additionally shows that the very organizational, procedural, and technological infrastructure that promises patients' increased access to records can also exacerbate some patients' "difficult" behaviors.

Introduction

Fueled by the promise of increasing efficiency and reducing costs, digital health is high on the agenda of policymakers and health care organizations alike. Many governments—including the United States and the United Kingdom (UK)—have developed electronic health roadmaps that incentivize the introduction of wearable sensors monitoring patients' health parameters; interoperable software programs for data sharing, storage, and management; and platforms for remote communication [1-5].

Electronic health records (EHRs), which store patients' medical history and administrative information in electronic form, play a crucial role in this process of digitization and integration of health care [1-2, 6]. They are also increasingly becoming directly available to patients for care management purposes [7]. In 2015, for example, the National Health Service (NHS) England mandated that by 2016 primary care providers give patients direct access to their records through dedicated online platforms [8, 9], which enable patients to retrieve first-hand information about their health and care. Such access is expected to allow patients to be more in control of and proactively improve conditions for their well-being, ultimately fostering safer and easier care,

boosting biomedical research, empowering patients, and promoting a "partnership" between citizens and health care professionals [10-12].

The idea that patients can access their EHR online without physicians' mediation is, however, controversial. Firstly, general practitioners (GPs) and other clinicians are concerned that the very fact of having access to records may have negative consequences for patients' welfare. For example, it could make patients anxious about their health conditions. Or it could expose some patients to coercive demands of third parties (e.g., abusive partners or employers) to access their records, thus jeopardizing patients' trust that their medical history will remain confidential [13-16]. Also, health care professionals are worried that patient access to records could increase risks of litigation, require them to change the way they write on the records, and invite patients to ask questions on specific phrasing, thus increasing GPs' workload [14, 17]. In this sense, patients who access their records might be more "difficult" for physicians to manage.

Eric Topol maintains that health care professionals resist the revolutionary changes that digital technologies are generating in the field of health care and medicine. In his latest book, *The Patient Will See You Now: The Future of Medicine is in Your Hands*, he argues that such resistance derives from the widespread and persistent paternalism of the medical profession [18]. According to this interpretation, by accessing health-related information via EHRs, patients would enter unmonitored into a space that was traditionally reserved for clinical experts, thus subverting the traditional power relationship in the clinic and endangering what some might regard as clinicians' undisputed authority.

It would be misleading, however, to interpret the controversy over patient access to EHRs as an irreducible tension between those who are keen to empower patients and those who are fearful that such empowered patients would be more "difficult" to manage because they could challenge clinicians' authority. Drawing on narratives of two patients in Northern England who have been accessing their EHRs for several years, I will argue that this tension inheres not in diverging ideologies but in the very practice of giving patients access to EHRs. I will also suggest that the very organizational, procedural, and technological structures that afford patient access to EHRs can contribute to patients being "difficult."

Stories of EHR Access and Patient-Physician Partnership
NHS England maintains that access to detailed medical information allows patients to make decisions about their care and lifestyle and, ultimately, control their health conditions [1, 9-12]. The underlying assumption is that information produces action, which results in control, which leads to (em)power(ment) that implies responsibility for healthy behaviors. In this liberal concept of "empowerment" [19], patients are not merely expected to act responsibly and promote their own health when duly informed of

their conditions. Empowered patients are also supposed to work in partnership with physicians for the promotion or restoration of their health. But what are the terms of such partnership in the practical context of EHR access?

Patients become more "useful." Indeed, having access to records may encourage patients to engage more in their care. This benefit clearly emerges in the story of a young lady (fictitiously called Eva) who, at the time I interviewed her in 2015 as part of a qualitative study of EHR use, had been accessing her full records for eight years. She could view her GPs' free text notes and hospital referrals, as well as her test results. As Eva explains, she usually checks her record before she sees a clinician "so I can have a good knowledge myself of what is going on before going to see the GP." She added that on several occasions, a reading of her records has allowed her to play a more active part in the diagnosis of her condition as she could help her GP make connections.

> So rather than just sitting there and listening to a GP I can say "Well I have got these symptoms and if you look over the past six months I have had this several times and things like that." You sort of become more involved in that process of figuring out what is going on.

Eva's account interestingly clarifies the way in which access to records fosters patients' agency: it allows them to take an auxiliary role in consultations. Rather than acting as [autonomous decision makers](#) in control of their health, patients are turned into disciplined assistants for clinicians.

Clinicians need to see the records. This collaborative relationship between patient and clinician maintains its traditional power asymmetry—an asymmetry that appears clearly in the story of Fiona (a pseudonym), an older patient with multiple morbidities whom I interviewed in 2015 as part of the same qualitative study of EHR use. On one occasion, her ophthalmologist would not schedule an eye surgery until she could be assured by the neurosurgeon that it would be compatible with Fiona's neck condition. Although the neurosurgeon wrote a letter giving the green light and the letter was stored in Fiona's GP records, the ophthalmologist could not access the letter from the hospital's informatics system. Fiona's assurance that the letter was in her records was not enough, as the ophthalmologist could not take the risk of scheduling a surgery when she had not seen the letter. Although Fiona was trustworthy enough to access her full EHRs and view information her own consultant could not retrieve, her word was not trusted, as the specialist needed to witness the presence of the letter in her records. In this asymmetry of decisional power and access to information, Fiona could still negotiate to use the ophthalmologist's computer to access her patient portal and show the neurosurgeon letter. As a disciplined assistant, Fiona inserted the digits to open her file and submit it to the expert eye of the physician who could then deliberate and schedule her surgery.

"*That's the way we do it.*" Such a supportive role is, however, informal and not always accepted. In some cases, patients' ability to access information is not acknowledged by health care professionals. As Fiona recalls, she had to take a penicillin allergy test, but the immunology department did not have access to her full medical records to check whether she had to suspend any medication before taking the test. Rather than trust Fiona or ask her to access her records on a department computer, the department waited to receive access to her full medical records through official channels. When the department finally got access to the relevant information and realized that indeed she had to suspend a drug she was taking, it was too late and Fiona's test was rescheduled six months later, delaying several other clinical treatments. A frustrated Fiona explains:

> The ridiculous part about it was [that] I was the person who gave that information about what medication I was on to the immunology consultant in the first place. So in other words they were chasing stuff around, information I had given them…. I said "Why didn't you ring me?" and they said "Because we needed to see it in the notes." And I said "Yes but I am the person who told you the information that went in the notes in the first place" [and they said] "That's the way we do it."

This time not only was Fiona not trusted about her account of what was in her records, she was also not allowed to assist the experts by granting them access. From Fiona's perspective, her consultants were being untrusting and dismissive of her access to correct information. From the point of view of the clinicians, Fiona could be perceived as "difficult" because she expected to be trusted on her word and did not seem to understand the safeguards in place to protect records' security. The impasse, however, is not due to a conflict between an empowered patient and a paternalistic clinician; instead, it is built into the organizational, procedural, and technological infrastructure that enables patient access to records.

Conclusion
Online, real-time access to records is expected to put patients in a position of power in the clinical relationship, as they have access to information that is traditionally reserved for clinical experts. In fact, digital access to health information in the UK might merely enable patients to take the role of assistants who engage in some form of useful labor that fills in the information gaps in current health care systems. Organizational and technological structures, however, may prevent even such a limited role, as clinical professionals are ultimately accountable for clinical decisions. This absence of patient power is exemplified in the last case discussed above in which Fiona had access to information her consultants could not directly access but could exercise no power or offer no assistance, as clinical responsibility finally rests with the health care professionals and puts them at the center of the flow of clinical information.

While policy roadmaps in the US, the UK, and other European countries incentivize digitally enabled "patient-centered" solutions that promise to give patients control and responsibility over their own health, existing health care infrastructures at the national level are not designed for patients to be in control and may even frustrate such attempts. This conflict between intention and its realization is not an ideological divergence between supporters of patient autonomy and empowerment and conservative paternalists protecting physicians' authority. In my interview with Fiona, it was apparent that consultants could not simply trust Fiona's words because they were operating in a system that normatively assigns to them the roles of protecting patient safety and information security as well as overseeing the fair distribution of health care resources. These normative roles are designed and implemented in an organizational, procedural, and technological infrastructure that requires them to "see with their own eyes" before making decisions. The same infrastructure also allows patients direct access to information that is not directly accessible to clinicians. The promise of patient self-management, control, and centrality in health care practices, therefore, is inherently at odds with the normative framework that guides the design of such practices.

It is crucial for policymakers to acknowledge these internal contradictions and to solve them by engaging in a dual task: redefining rights, duties, and responsibilities within our health care systems to include patients in more active roles while, at the same time, nuancing the rhetoric of empowerment via access to records to realistically express the role that patients can have in the context of their care.

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Roles of Physicians and Health Care Systems in "Difficult" Clinical Encounters

Elizabeth S. Goldsmith, MD, MS, and Erin E. Krebs, MD, MPH

Abstract

Physicians are, by definition, contributing partners in "difficult" patient-physician encounters. Although research on relevant physician qualities is limited, common themes mirror the more extensive literature on physician burnout. Focusing on primary care, we discuss physician-level factors in difficult encounters related to psychosocial attitudes and self-awareness, communication skills, and practice environments. Potential approaches to mitigating these factors include changes to medical training, such as structured peer case discussion groups and communication skills development, and changes to workplace environments, such as integrated mental health. Modifying physician-level factors in difficult encounters could ease perceived difficulties and improve outcomes for both physicians and patients.

Introduction

The "difficult patient" is a long-standing focus of medical scholarship and a common topic of discussion among physicians. "Difficult patients" have been defined primarily from the perspective of physicians, with most studies conducted in primary care settings. These studies are fairly consistent in their characterization of "difficult patients" as more likely to have multiple physical symptoms, high health care utilization, or functional impairment related to mental health diagnoses or substance dependence [1-3].

Of course, it takes two to tango, so what about "difficult doctors"? Here, we do not focus on physicians who commit malpractice or patient abuse but on the broad category of physicians most likely to be involved in subjectively difficult physician-patient encounters. We are not aware of studies that have identified such "difficult physicians" from a patient or third-party perspective. Instead, research on the physician side of difficult interactions has focused on physicians who report more "difficult patients" or difficult encounters than their colleagues do [1, 4-13]. Such "difficult doctors" might be more accurately described as physicians with a lower difficulty perception threshold. Regardless of what we call them, physicians who see relatively more encounters as difficult or frustrating have been the focus of a small number of studies from which a preliminary profile has emerged.

Research on the "Difficult Physician"

Physicians who perceive more encounters as difficult report having more negative attitudes about psychosocial aspects of medicine, less experience or training, and more work-related stress or dissatisfaction than their colleagues who report fewer difficult encounters. In the national Physicians Worklife Survey, physicians who considered high proportions of patients "generally frustrating to deal with" were more likely than their less-frustrated colleagues to be under 40 years of age, work more hours, have higher stress, and report caring for more patients with complex psychosocial and substance abuse problems [4]. In the Minimizing Error, Maximizing Outcomes Study, physicians who considered more encounters difficult were younger, more likely to report burnout, and less likely to report high job satisfaction than those who considered fewer encounters difficult [5]. A study of British general practitioners found that those reporting more "heartsink" patients had greater perceived workload, lower job satisfaction, and less training in counseling and communication skills than those reporting fewer heartsink patients [6]. Two studies examining physicians' perceptions of walk-in visits found that physicians who considered more encounters to be difficult were more likely to have negative attitudes about psychosocial aspects of care [1, 7]. Qualitative research also has identified clinician traits that may contribute to clinicians' tendency to perceive more encounters as difficult, many of which mirror the above findings: limited training in psychosocial care, difficulty setting boundaries, poor communication skills, emotional burnout, exhaustion, and perceived time pressure [8-13].

Physician Burnout and Physician-Perceived Difficulty

Findings from literature on physician-related factors in difficult encounters have intriguing parallels with research on physician burnout. Reported job dissatisfaction and burnout are themselves characteristics of physicians who perceive more encounters as difficult [4-6, 8-10, 13], and physician burnout and difficult physician-patient encounters might have similar causes and consequences. Physician burnout is a complex construct that incorporates dimensions of practice environment, social and cultural influences, and personal qualities [14, 15]. Although age, gender, and specialty do not consistently predict burnout [16, 17], limited self-awareness and inability to set professional and personal boundaries do [18]. These self-awareness and boundary challenges are also noted in physicians who perceive more encounters as difficult [8, 10-12]. Similarly, both physicians who report high burnout levels and physicians who report more difficult encounters describe their workplaces as characterized by limited control over scheduling and by high workload and time pressure [4-6, 17-20]. Improvement in factors common to physician burnout and physician-perceived difficult encounters may mitigate both of these pressing problems. In what follows, we focus on three key categories of physician-related qualities—psychosocial attitudes and self-awareness, communication skills, and

practice environments—that contribute to difficult patient-physician encounters and on the teaching of skills that might reduce such encounters.

Psychosocial Attitudes and Self-Awareness
Negative attitudes toward psychosocial care, a common theme in existing research on difficult physicians, develop under mixed influences of medical training and individual physicians' personal backgrounds [21, 22]. Medical training's focus on pathophysiology has important implications for our approach to biopsychosocial problems: disproportionate attention to the biological aspects of these problems implies psychosocial aspects are secondary or separate—beyond our scope of practice [23]. Physicians' own psychosocial attributes and self-awareness also matter for patient care [21, 22]. Some physicians are well aware of the cultural influences of race, ethnicity, gender, or sexual orientation on their own identities and might easily recognize tensions related to such influences within medical encounters [24]. Other physicians may have a hard time seeing their personal background as culturally relevant and recognizing how their backgrounds can influence patient interactions. In addition, some attributes of physicians who perceive more encounters as difficult, such as discomfort with uncertainty and inability to set boundaries [8, 10], are personal qualities that people can have difficulty identifying and modifying in themselves [22]—and that can worsen physician burnout if unaddressed [18]. Mentored development of self-awareness skills might help to reduce both physician burnout and perceived difficulty of encounters.

Several approaches have been developed to support clinicians in psychosocial insight and self-reflection in both educational and practice settings, including structured peer-case discussions such as modified Balint groups and Schwartz Rounds™. Introduced by Michael and Enid Balint in the 1950s and grounded in psychoanalysis, Balint groups are small clinician groups that meet regularly to discuss patient interactions that participants have found difficult [25, 26]. Such groups aim to help physicians gain perspective on the role their own traits, attitudes, and behaviors play in difficult encounters and develop skills they can apply in future practice [25, 26]. Schwartz Rounds build similar principles into interactive case discussions in the larger, familiar grand rounds format, again focused on improving psychosocial and personal awareness for the sake of improved patient communication and care as well as physician support [27]. Interestingly, this emphasis on physician self-awareness and on completing the "emotional work" of difficult patient interactions [28] was fundamental to the concept of patient-centered care as described by Balint in 1969 [25]. Although evidence suggests structured group discussions may help build practical self-reflection habits into medical training and can ultimately improve job satisfaction [13, 27], approaches to improving physician self-awareness have remained on the margins of undergraduate and postgraduate medical training [29]. Further research is needed to determine whether their broad implementation could lead to substantial improvements in patient care and physician well-being [26]. More educational grounding in the biopsychosocial model of health, with

structured training in self-awareness and communication skills, could produce physicians who find—and make—care less "difficult" for all involved.

Communication Skills

Success in a healing role—an important source of personal meaning and professional satisfaction for many doctors [8, 10, 18]—requires high-level communication skills. Physicians must convey nonjudgmental interest, empathy, and respect to build the therapeutic alliance while efficiently accomplishing clinical tasks [8, 10, 30, 31]. Insufficient communication and patient management skills can impede clinical care, compound physicians' emotional work, and predispose physicians to burnout [11, 13, 14, 30].

Patient-centered communication and shared decision-making involve skills that have become increasingly well-defined through research [32, 33]. In many common symptomatic conditions, physician communication is the core intervention. For example, acute back pain guidelines recommend self-care advice and education but no diagnostic tests or specific treatments for most patients [34]. Training primary care physicians to effectively communicate this advice improves patient distress and reduces additional care seeking [35]. In many chronic conditions, such as diabetes and longitudinal HIV care, effective communication and perceived patient-centered care can promote adherence to prescribed treatments and behavior change recommendations [30, 36-41]. Furthermore, physicians who use communication skills effectively report more positive experiences of patient care, particularly with psychosocially challenging diagnoses [42, 43].

Communication skills can be taught effectively in medical training environments, both to medical trainees and to their teachers [33, 44]. Nevertheless, most medical schools and residency training programs do not have structured or specific approaches to improving communication skills or ensuring communication competency [32, 33]. More widespread training in techniques such as motivational interviewing, an interactive approach that elicits and engages patients' intrinsic motivation to make personal changes, could improve physicians' effectiveness in the management of a wide range of complex conditions requiring behavior change [45]. Outlining specific communication skills and tactics in policy documents, such as the residency program requirements issued by the Accreditation Council for Graduate Medical Education (ACGME), and building specific communication skills assessments into testing environments such as the objective structured clinical examination (OSCE), could motivate medical schools and residency programs to build up such training. Medical education developers seeking guidance can look to the training programs of our colleagues in clinical psychology and other mental health professions, which have prioritized communication skills development for some time.

Finally, it is a long-standing reality that medical training often occurs in low-resource environments—problematic for patients for many reasons and also for trainees and early-career physicians who might feel least equipped to handle complexities of care. The challenges of care in low-resource settings make it all the more important for training environments to impart communication and personal awareness skills that can have short- and long-term benefits to both physicians and patients [33].

Practice Environments
We must acknowledge the role of practice structure and resource limitations in generating both difficult encounters and physician burnout in primary care settings. Organizational interventions addressing workplace factors might be an effective means of reducing both physician burnout and difficult encounters, although research to date comprises a limited number of studies and a wide variety of approaches, ranging from simple scheduling changes to intensive multifaceted interventions [46].

Perceived time pressure is a common problem cited by both physicians who perceive more encounters as difficult and physicians with high burnout levels [6, 8, 10, 16, 17]. Assessment and management of complex biopsychosocial problems requires time that physicians often don't have or cannot be paid for and can require skills beyond even optimally trained physicians' scope. Even sophisticated interventions targeting psychosocial care are more likely to fail when time, reimbursement, and resources are lacking. For example, a recent trial of a structured behavioral/mental health risk assessment intervention in primary care clinics was successful in its goals of identifying many clinically relevant problems and triaging care but was ultimately found to be too time-consuming to be sustainable in real-world practice [47, 48].

Team-based approaches have the potential to achieve what individual physicians cannot. For example, integration of mental health professionals into primary care settings improves both quality of medical care and patient outcomes [49]. Although this might be a particularly promising approach to addressing psychosocial challenges in primary care, effects on physician outcomes such as burnout are in need of research. A more transformational approach to primary care, the patient-centered medical home model, is a complex organizational intervention intended to make care more team-based, coordinated, and accessible. The patient-centered medical home approach has demonstrated ability to improve patient experiences and delivery of preventive care services [50], but evidence on physician outcomes is somewhat conflicting. A 2013 systematic review found low-strength evidence of beneficial effects on primary care staff satisfaction [50]. More recently, however, one study found that the Veterans Health Administration's patient-centered medical home transformation was associated with a modest increase in primary care physician turnover [51], and another study found no relationship between the level of medical home implementation and burnout prevalence among primary care employees [52]. More research is needed on physician

outcomes of such organizational interventions and on the mechanisms by which these outcomes are achieved.

Conclusion

"Difficult doctors"—or, more accurately, physicians who often report frustration or difficulty with patient encounters—might have more negative attitudes about psychosocial aspects of medicine, less experience or training in relevant skills, and more work-related stress or dissatisfaction. These qualities mirror those found among physicians experiencing burnout and suggest opportunities for improvement in both training and practice organization. Graduate and postgraduate medical education present particularly important opportunities—too often missed—to ensure competency in self-reflection and critical communication skills; it is time to leverage training to teach these skills more pragmatically and effectively. Primary care practice changes, such as integrated mental health, the patient-centered medical home, and other organizational approaches might deliver better patient care and have the potential to improve physician well-being; more research is needed to determine when, where, and how such organizational changes can live up to this potential. Such training and practice changes merit further investigation to determine whether and how they might ease perceived difficulties for both physicians and patients, in line with the fundamental principles of patient-centered care.

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HISTORY OF MEDICINE

How Navigating Uncertainty Motivates Trust in Medicine

Jonathan B. Imber, PhD

Abstract

Three significant factors in the shaping of modern medicine contribute to broad perceptions about trust in the patient-physician relationship: moral, professional, and epidemiological uncertainty. Trusting a physician depends first on trusting a person, then trusting a person's skills and training, and finally trusting the science that underwrites those skills. This essay, in part based on my book, *Trusting Doctors: The Decline of Moral Authority in American Medicine* (Princeton University Press, 2008), will address the forms of uncertainty that contribute to the nature of difficult encounters in the patient-physician relationship.

Introduction

The social boundaries of trust extend from the interactions between people familiar with one another to the complex realm of civil society. Few are unfamiliar with the breakdown in trust between people whose relationships are primarily emotionally based (as divorce statistics indicate). Furthermore, few doubt the contentiousness of contemporary politics in which trust between different groups has broken down. Physicians have navigated these boundaries for millennia. Oaths and—since the nineteenth century—codes of ethics [1] have iterated expectations that are intended to shape the scope of responsibilities that at once define the meaning of profession and, I argue, vocation.

From this perspective, trust in medicine can be conceived on a continuum: it is manifest at one end in patients' reliance on the person and character of their physician and, at the other end, in both patients' and physicians' reliance on medical-scientific research and a particular treatment's effectiveness. Between these two ends is the idea of professionalism represented as "detached concern" [2, 3]. Such concern speaks to a tension between empathy and emotional over-identification; that is, a physician must preserve a measure of respectful distance but nevertheless display some measure of concern that is felt by the patient. Somewhere along that continuum at the center of professionalism, the kinds of uncertainties to be elaborated here help explain how difficult encounters in medicine emerge. Such encounters may at first be attributed to patient behavior alone, but physician behavior can also contribute to difficult encounters.

Moral Uncertainty

Various behaviors on the part of physicians implicate them in moral failings of different kinds. The "impaired physician" represents the pathological side of moral trust in medicine [4]. An impaired physician violates expectations of competence but also patients' elemental expectations of trust about the person attending to them [5]. The nature of difficult encounters with patients is reflected in part in the [litigation](#) of malpractice suits or criminal prosecutions. For example, a physician who breaks the law—for example, by participating in Medicaid and Medicare fraud, particularly when the motivation is pecuniary rather than an interest in the patient—is also morally untrustworthy [6]. Finally, concerns about a physician's ties to larger commercial interests remain a matter of perennial scrutiny [7]. Such forms of behavior are first defined in terms of the actions of persons, although a focus on systemic problems in the delivery of medical care sometimes obscures the actions of individuals [8, 9]. Moral uncertainty, then, is distinct from the larger social forces that are intertwined with politics in particular.

Professional Uncertainty

In recent years, the emergence of online evaluations of individual practitioners has become nearly ubiquitous. Surveys abound sent by corporate-run health care systems that ask patients to evaluate a particular clinical visit, including questions about the cordiality and professionalism of staff [10]. Historically, professionalism was dictated by physicians themselves in the careful organization of training from the start of medical school through residency [11]. What has not changed substantially is the locus of oversight for medical training, although there has been a rebalancing such that now patient care receives as much attention as medical training. This rebalancing occurred as a result of the well-known Libby Zion case, in which a young woman died because the resident physicians treating her were not aware that the painkiller they administered interacted with the antidepressant she was taking [12, 13]. Controversy over responsibility to patients implicated attending physicians and residents alike in unanticipated ways and introduced a new layer of policy oversight involving [resident duty hour requirements](#) that reverberates now throughout the health care system [14]. Unlike moral uncertainty, professional uncertainty is a result of increased surveillance of clinical practice, expressed as an increase in testing for ever-more refined diagnoses, some of which tests are helpful and some of which create unnecessary anxiety from false positives, as in the cases of cervical, breast, and prostate screening [15, 16]. These false positives consequently contribute to a diminution of physician authority. Patient distrust of medical professionals is also evident when patients use the internet to find information that can be used to question an individual physician's authority [17].

Epidemiological Uncertainty

The foundation of trust in modern medicine is symbolized by the scientific progress in all medical specialties and, indeed, in specialization itself. Trust in medical knowledge gave

rise to what has been called the "golden age" of medicine, roughly from the beginning of the twentieth century until the 1950s [18]. Striving to meet the challenge to reduce the onset and spread of infectious and chronic diseases and their attendant morbidity and mortality has been central to that progress. What is described as the "epidemiologic" or "epidemiological" transition—changing population patterns of mortality and causes of death, for example—has been a subject of long-standing debate among medical historians, especially in the role that chronic disease epidemiology has played in the evolution of public health [19, 20]. Factors that have contributed to more than a century's decline in infectious disease and a corresponding increase in chronic illness have given rise to important ideas such as "risk factors" as one important basis of modern public health [21].

The history of tobacco consumption and its control introduced, by way of prospective epidemiological studies, a new understanding of the causal relationship between behavior (e.g., smoking) and the delayed onset of chronic illnesses [22, 23], in which uncertainty will always remain. Physicians were faced with providing advice based increasingly on the estimated risk of developing lung cancer or another disease [24], which cannot predict whether a particular person will develop the disease in question. Although a patient's behavior becomes a clinical problem only with the onset of a chronic illness, epidemiological knowledge offers a basis for predicting the chance of developing a specific disease over the course of a lifetime [24]. The focus on tobacco and its association with chronic illness led to several generations' worth of epidemiological investigations of the relationship between individual behavior and the risk factors heretofore less understood [25].

The decline in confidence in professional authority in particular is linked to the new forms of knowledge about health. The risk estimates yielded by prospective studies are the twenty-first century source of anxiety about how health and disease are to be understood [26, 27]. Confidence in the care offered by physicians is mediated and potentially undermined by this epidemiological uncertainty, especially among the worried well [28, 29]. The gap between knowledge of the cause of disease and uncertainty about whether it will occur in any particular individual is a great source of anxiety among these same people [28, 29].

The Significance of Trust for the Medical Vocation
The advancement of medicine as a profession and as a foundation of effective knowledge has deep cultural roots that are inevitably tied to the ways that human beings understand and experience suffering. William James recognized that, by the end of the nineteenth century, what he described as "a strange moral transformation" had already preceded scientific advances in the alleviation of pain and suffering. He wrote in his chapter on "Saintliness" in *The Varieties of Religious Experience*:

A strange moral transformation has within the past century swept over our Western world. We no longer think that we are called on to face physical pain with equanimity. It is not expected of a man that he should either endure it or inflict much of it, and to listen to the recital of cases of it makes our flesh creep morally as well as physically. The way in which our ancestors looked upon pain as an eternal ingredient of the world's order, and both caused and suffered it as a matter-of-course portion of their day's work, fills us with amazement [30].

In one sense, what James identified was very much the opposite of the nearly canonical view today that progress in scientific understanding and technological innovation outpace our moral capacity to respond to them [31]. On the contrary, the most significant cultural change began to take shape over a century ago in the rhetoric of suffering, the strange moral transformation that pain and the suffering caused by it were not and did not have to be inevitable. This change alone has been instrumental in encouraging the ambitions of both science and technology to the present moment [32].

Physicians and patients face challenges in an era of uncertainty about whether the authority of practitioners is vested in the person, the profession, or medical knowledge; and the different forms of uncertainty stemming from these respective domains contributes to the nature of difficult encounters in the patient-physician relationship. In all three cases, public anxiety has steadily grown as trust has declined, contributing to difficult encounters between patients and their caretakers. Although outright violence against physicians is rare, physicians' failures to communicate uncertainty effectively to patients and their families can result in tremendous disappointment and distrust [24].

In recent years a significant movement has emerged composed of practitioners in health care who have sought to revitalize the calling of medicine by improving contact and communication with patients and their families and by appealing to what the faith traditions might contribute to a more fulfilling practice of medicine [33-35]. At the same time, physicians and others have written on a renewed sense of the calling of medicine in the face of the inevitable and larger reality of health care challenges and reform, arguing for exemplary forms of commitment to patients by each practitioner [36-39]. Resistance to various macro-social types of managed care—whether corporate, governmental, social-scientific, or bioethical—has grown from the bottom up, as it were, led by individual doctors and nurses who recognize the need to resist certain transformations in the practice of medicine that have exacerbated uncertainties about diagnosis, treatment, and outcome. These transformations were noted forty years ago by the sociologist Talcott Parsons [40], who spoke about three models in medicine:

The first is the *market* model which regards the patient as a "consumer" with the implications that the health care agent, notably the physician,

should be regarded as the seller of a service, and that the basis of the relationship is primarily economic. The second model is that of *bureaucratic organization* which would be appropriate to predominantly administrative functions as in the tax collection agency…. Closely related to the bureaucratic model is the notion of the proletarianization of the medical profession. The third model, which appears on a more implicit level, is that of the doctor-patient relationship as a *democratic association*. While each of these models has a range of applicability, each also has serious limitations [41].

Parsons identified two new models, the patient as consumer (i.e., a market model) and the physician as employee (i.e., a bureaucratic model), which a half-century later have their advocates and critics. But he was not arguing against a reality in which "health care is a service and … must be financed in some way or other" [41] and in which consumerism and proletarianization would be the new and dominant forces in its provision. Rather, he was lamenting his social science colleagues' macro-social assessments that such a reality would inevitably take a certain shape or should be further pursued or advocated. He sought to acknowledge physicians' asymmetric power by placing it in a larger context of their necessary and inevitable authority that should not be bought and should not be defined by bureaucratic fiat.

These developments at the macro-social level have complicated physician-patient encounters in both measurable and immeasurable ways, making trust all the more difficult to sustain and creating the contexts that make difficult encounters more likely. The sentiment that the practice of medicine involves an encounter first and foremost between persons remains the medical profession's *raison d'être*.

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IMAGES OF HEALING AND LEARNING

Nested Tensions in Care

Artwork and captions by Merel Visse, PhD

Abstract

This project presents research-based art works that inquire into the tensions in everyday life from an ethical viewpoint of care, which sees people as embedded, "nested" in care-based relationships. Trust is the glue that holds these "nests" together. Care is the air that lifts them up, but tensions exist as well—between dependency and autonomy, vulnerability and strength, for example. The pull of these ideas exist in a kind of "check" and run through our relations and being.
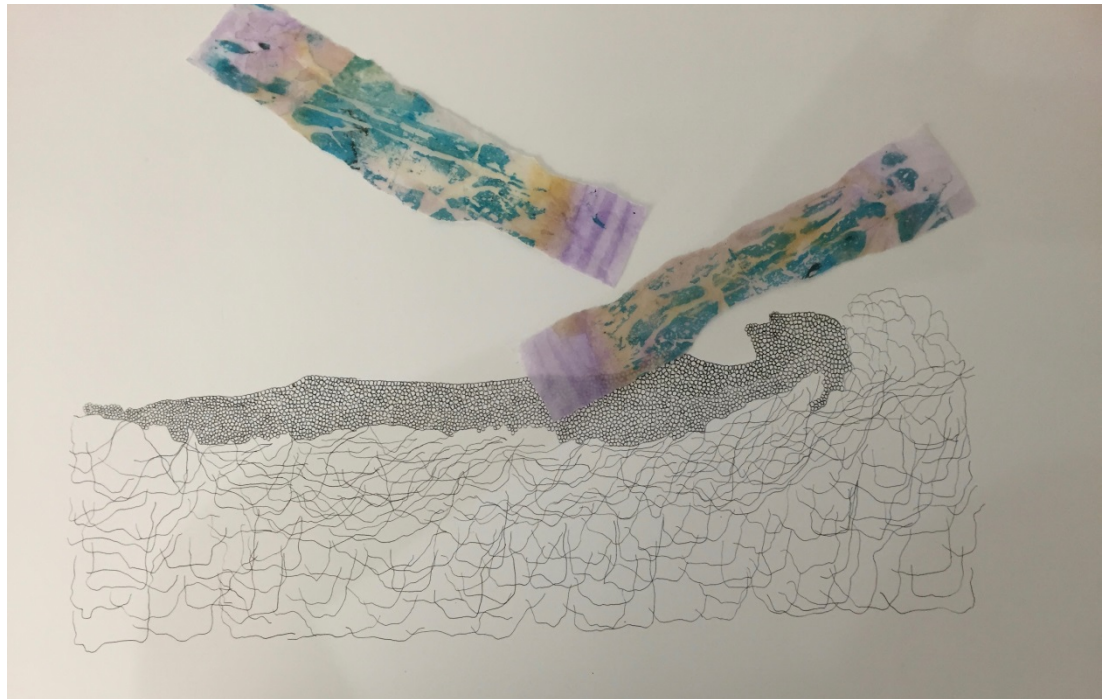
Figure 1. Detail of *Untitled*, by Merel Visse

Caption

Untitled, ink and mixed materials on paper, explores spiritual dimensions of care. It was created during my summer residency at the New York School of Visual Arts in August 2016 and is part of a collection of works, *Nested Tensions in Care*.
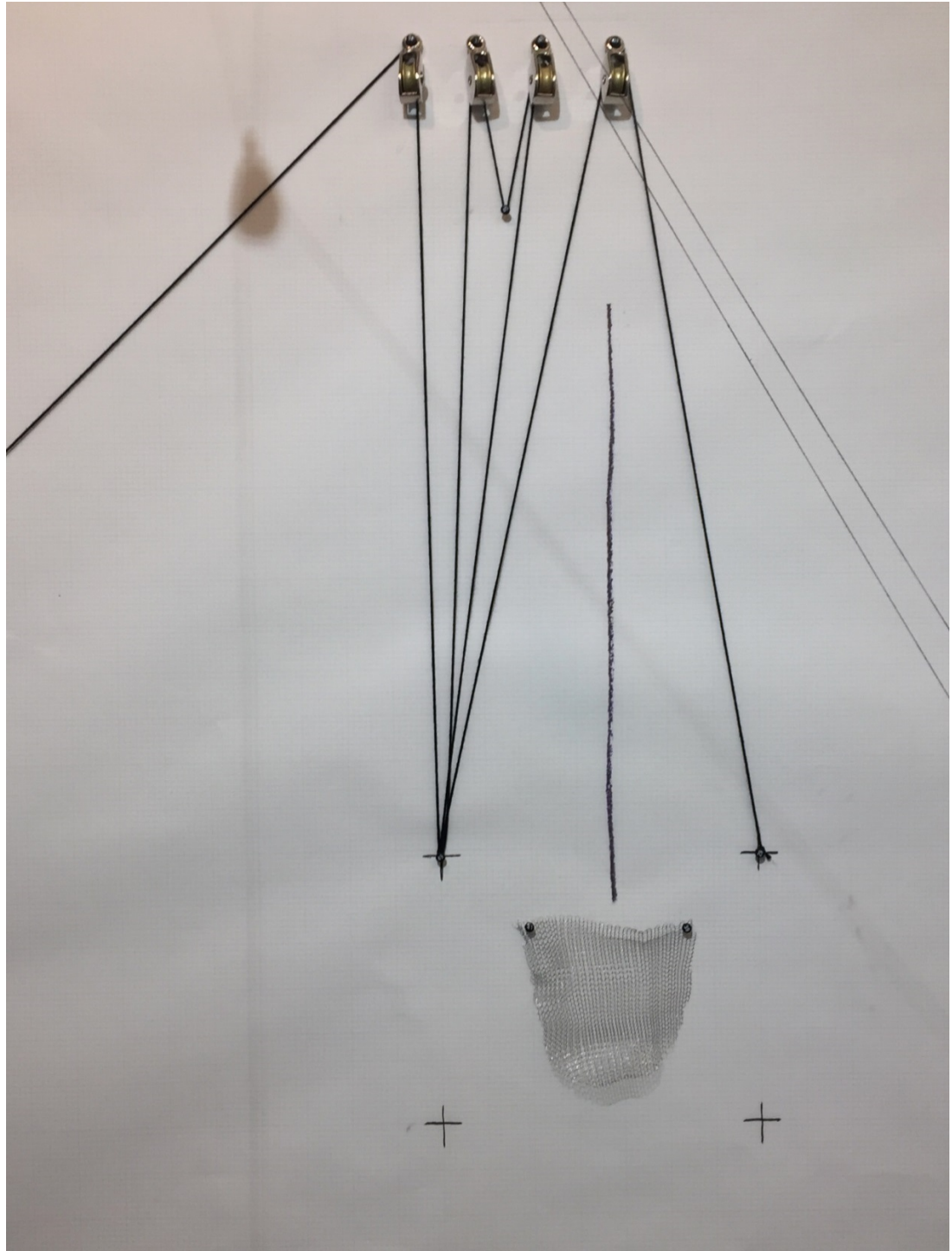
Figure 2. Detail of *Tension*, by Merel Visse

Caption
This fragment, made of pulleys, thread, iron, and paper, is part of a wall-to-wall installation titled *Tension*. It inquires into the asymmetries, reductions, expansions, and relationships among "push" and "pull" forces at play among stakeholders in health care. The "enclosed" nest at the bottom is a representation of physicians' tendencies to capture people's illness experiences primarily as diagnostic classifications.

Figure 3. Detail of *Nest*, by Merel Visse

Caption

This is a wall-object titled *Nest*—made of ink, watercolor, and textile on paper—which is part of a three-dimensional installation that is pictured and discussed below. My artistic interests in "nests" began with hospital beds as both a secluded and a public space. Gaston Bachelard's inquiry into the experience of intimate spaces [1] further inspired my exploration of nests as sites of health care experiences for both patients and clinicians. Bachelard writes about an encounter that I find to be a fitting metaphor for how clinicians and other caregivers could visit a patient's bedside.

> Gently I lift a branch. In the nest is a setting bird. But it doesn't fly away, it only quivers a little. I tremble at having caused it to tremble. I am afraid that this setting bird will realize that I am a man, a being that has lost the confidence of birds. I remain motionless. Slowly the bird's fear and my own fear of causing fear are allayed—or so I imagine. I breathe easily again, and let go of the branch. I'll come back tomorrow. Today, I am happy, because some birds have built a nest in my garden [2].

Figure 4. Detail of *Nests*, by Merel Visse

Caption
Nests is a three-dimensional installation that consists of several objects (nests) made of mixed materials (ink, textiles, and watercolor on paper, thread, and metal). The nest can be a symbol of the isolation and seclusion of health care experiences, on the one hand, and a symbol of connection and community, on the other.

Figure 5. Detail of *Interdependence*, by Merel Visse

Caption
This wall object (ink and pastel on transparent paper) explores our dependence—a
function of our bodily fragility—and our interdependence. It illustrates how my husband
and I—him being black, me being white—are interdependent and how that
interdependence constitutes my body and well-being. Care ethicists often speak about

"nested dependencies" in care [3], so this work considers one important confluence between ethics and aesthetics.

Nested Tensions

This project [4] is born out of need for further exploration of care as a space for listening and being responsive to and present for another person, and it is associated with kindness and love. But entering and occupying spaces of caring, by oneself or with others, can also be confusing, threatening, and frightening. These experiences of health care, in particular, can be invisible and difficult to grasp by the people involved, including clinicians, patients, and patients' loved ones. Tensions between good and bad, beautiful and ugly arise, because when one cares or receives care, differences between different stakeholders' worlds come into contact and, perhaps, conflict. Some differences have a small impact, others are severe in their effects. For example, in our vulnerability, we might like it if our pillow is pushed just a little more so it supports our back just right, but someone—even someone with good intentions—pushes it too hastily, and our needs are not quite met. Or we might hope an administrator or caregiver cares about our request, and then we must navigate our disappointment when we get a "right" response—perhaps out of a sense of obligation—that nonetheless feels icy in the absence of genuine intentional empathy.

In these situations, our relationships with others are "nested" and pose ethical and aesthetic complexities, as explored in these works of art. As soon as we care or receive care, we find ourselves in an intricate play. We are (inter)dependent. We all have expectations, hopes, and demands that "pull," with tension and heft to weigh us down or lift us up.

One response could be to try to resolve these tensions. Present-day society is focused on controlling some of these tensions, perhaps by developing guidelines, rules, and systems-based regulations. This research-based art project never "resolves" tensions and instead proposes the wisdom of less control; tensions can have structural and creative value for us as human beings because they hold items in tension in place, perhaps in balanced suspension if only for now, for our further collaboration and careful exploration. Nested tensions constitute who we are in the spaces of caring. *A la* the French philosopher Paul Ricoeur [5], this art project sees these tensions in health care experiences as necessary for solidarity and trust—two pillars of a caring democracy [6]. When tensions are held, when we hold them for each other, new spaces to breathe might be found.

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